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
	MHL092-859	A. BUILDING: _____ B. WING _____	R 07/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DESTINY FAMILY CARE HOME 2	1238 FAIRLANE ROAD CARY, NC 27511

(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 July 22, 2024. The complaints were unsubstantiated (Intake #NC00217216 & NC00218383). 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 5. 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	V 105	V105 The facility administrator previously applied for the CLIA waiver and has not yet received the waiver. Administrator will follow up.	

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V 105	Continued From page 1 can provide services to address the individual's 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 review and interview, the facility failed to develop and implement adoption of standards that ensured operational and programmatic performance meeting applicable standards for the CLIA (Clinical Laboratory Improvement Amendments) waiver. The findings are:

Review on 6/18/24 of a partial record for client #3 revealed:
- Admitted 8/10/23
- Diagnoses of Type 2 Diabetes Mellitus, Schizoaffective Disorder, Hypothyroidism, & Hyperlipidemia
- A physician order dated 8/10/23: check blood sugar (BS) four times a day (Diabetes)

During interview on 6/18/24 staff #1 reported:
- she checked client #3's BS 4 times daily

During interview on 6/18/24 the Qualified Professional reported:
- she had discussed a CLIA waiver with the Licensee
- the Administrator was responsible for obtaining the CLIA waiver
- she thought the Administrator had started the process and did not know why the Administrator had not obtained the CLIA waiver yet

During interview on 6/18/24 the Administrator reported:
- The facility did not have a CLIA waiver
- She did not know she needed a CLIA waiver

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V 111	Continued From page 4	V 111		

This Rule is not met as evidenced by:
Based on record review and interview, the facility failed to ensure admission assessments were completed for 1 of 3 audited clients (#3) and 1 of 2 former clients (FC #6). The findings are:

Review on 6/18/24 of a partial record for client #3 revealed:
- Admitted 8/10/23
- Diagnoses of Type 2 Diabetes Mellitus, Schizoaffective Disorder, Hypothyroidism & Hyperlipidemia
- No documentation of an admission assessment

Review on 6/20/24 of FC #6's record revealed:
- Admitted 6/5/24 and discharged 6/6/24
- Diagnoses of Posttraumatic Stress Disorder, Intellectual Developmental Disorder, Major Depressive Disorder & Asthma
- No documentation of an admission assessment

Interviews on 6/19/24 & 6/20/24 the Qualified Professional reported:
- Client #3 was admitted on 8/10/24
- The Administrator was responsible for completing client's admission assessments upon admission
- Knew client #3's admission assessment was completed, but she couldn't find client #3's client record
- Was not aware FC #6 was admitted or

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V 111	Continued From page 5 discharged from the facility Interviews on 6/18/24 & 7/22/24 the Administrator reported: - Was responsible for completing client's admission assessments - She completed client #3's admission assessment, but she could not locate client #3's client record - FC #6's admission assessment wasn't completed because FC #6 "was only in the home (facility) for about 10 hours" and she "didn't get a chance to do it"	V 111		
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;	V 118	V118 – As of 7/23/24, the facility has completed training for all employees working at this particular home on following Dr's orders as written, medication documentation, ensuring the MARs are kept current as medications are administered and proper medication disposal. The administrator will monitor.	

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V 118	Continued From page 6 (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 observation, record review and interview, the facility failed to administer medications on the written order of a physician for 1 of 3 audited clients (#3). The findings are: Review on 6/18/24 of a partial record for client #3 revealed: - Admitted 8/10/23 - Diagnoses of Type 2 Diabetes Mellitus, Schizoaffective Disorder, Hypothyroidismn& Hyperlipidemia - Physician orders dated for the following: - 8/10/23: check blood sugar (BS) four times a day (QID) (Diabetes) - 6/17/24: Humalog 200 units (U) Inject before meals based on sliding scale: If blood sugar (BS) is 80-150 take 8 U, 151-200 take 10 U, 251-300 take 14 U, 301-350 take 16 U & 351-400 take 18 U (Diabetes) - 9/20/24: Lantus 100U inject 38U subcutaneously in the evening (Diabetes) Review on 6/18/24 of client #3's April, May, & June 2024 MARs revealed: - No documented BS readings	V 118		

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V 118	Continued From page 7 Review on 6/18/24 of client #3's BS log revealed: - BS readings were documented once on 6/4/24, and QID from 6/5/24-6/8/24 - No BS readings were documented from 8/10/23-6/3/24 Observation & interview at 12:18pm on 6/18/24 client #3 reported: - Checked her BS QID - Monitored her BS closely with her physician - Went to her physician ever two weeks because her BS was "so high" - Had a device she wore daily that alerted her if her BS was too high - Was prescribed insulin & injected the insulin daily - Staff recorded her BS readings in a notebook - Client #3 went to the kitchen and retrieved the BS reading notebook out of a drawer - Couldn't recall where the old BS log was located Interview on 6/18/24 staff #1 reported: - She checked client #3 BS QID at 8am, 11am, 4pm & 8pm - Documented the BS readings in client #3's BS log Interview on 6/18/24 the Administrator reported: - Staff checked client #3's BS QID and documented the readings in a BS log - Couldn't recall where client #3's old BS log was located that contained client #3's readings prior to June 2024 - Client #3 had a doctor's appointment on 6/17/24 and the BS log could have been left at there	V 118		

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V 119	Continued From page 8	V 119		
V 119	27G .0209 (D) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (d) Medication disposal: (1) All prescription and non-prescription medication shall be disposed of in a manner that guards against diversion or accidental ingestion. (2) Non-controlled substances shall be disposed of by incineration, flushing into septic or sewer system, or by transfer to a local pharmacy for destruction. A record of the medication disposal shall be maintained by the program. Documentation shall specify the client's name, medication name, strength, quantity, disposal date and method, the signature of the person disposing of medication, and the person witnessing destruction. (3) Controlled substances shall be disposed of in accordance with the North Carolina Controlled Substances Act, G.S. 90, Article 5, including any subsequent amendments. (4) Upon discharge of a patient or resident, the remainder of his or her drug supply shall be disposed of promptly unless it is reasonably expected that the patient or resident shall return to the facility and in such case, the remaining drug supply shall not be held for more than 30 calendar days after the date of discharge. This Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to dispose of medication affecting 1 of 3 audited clients (#5). The findings are:	V 119	V119 – As of 7/23/24 medication training was completed for the staff in this home. Expired and spilled/loose medications shall be disposed of by flushing into a septic or sewer system (with a witness), or by transfer to a local pharmacy for destruction. A record of the medication disposal shall be maintained by the program if controlled.	

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V 119	Continued From page 9 Review on 6/18/24 of client #5's record revealed: - Admitted: 7/28/22 - Diagnoses: Schizoaffective Disorder, Hyperlipidemia, Type II Diabetes Mellitus & Tobacco Disorder - FL2 dated 6/4/24 with the following: - Risperidone 3 mg (milligrams) take one half tablet by mouth in the morning (Schizophrenia) - Risperidone 3 mg take one and one half tablet by mouth at bedtime - Benztropine 1 mg take one tablet by mouth at bedtime (Tremors) Observation at approximately 11:30am on 6/18/24 of client #5's medication bin revealed: - A pill packet labeled for Benztropine 1mg that contained small white oval pills - A pill packet labeled for Risperidone 3mg that contained small beige round pills - 4 small white oval pills, identical to the pills inside of the Benztropine pill packet, located at the bottom of the medication bin - the small white oval pills in the bottom of the medication bin were broken in half - 1 small beige round pill, broken in half, identical to the pills inside the Risperidone pill packet, located at the bottom of the medication bin Interview on 6/18/24 client #5 reported: - been at the facility for about 2 years - she took medication daily as prescribed Interview on 6/18/24 the Administrator reported: - she was responsible for checking medication bins - she checked them every month - the pills were not in the bottom of the bin the	V 119		

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V 119	Continued From page 10 last time she checked them - the Benztropine and Risperidone pills were popped out of the pill packets but staff could not find them so they popped out another pill - client #6 did not miss any scheduled administration of Benztropine or Risperidone	V 119		
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 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	V 289	V289 - The surveyed clients will be reassessed to determine the appropriateness of the current placement. For one of the clients an exemption/waiver for one of the clients. It is the responsibility of the administrator to involve the QP and/or to let the QP know when there's a new admission.	

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V 289	Continued From page 11 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). This Rule is not met as evidenced by: Based on record review and interview, the facility failed to operate within the scope of their program by admitting clients without developmental disabilities affecting 2 of 3 audited clients (#3 & #5). The findings are:	V 289		

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V 289	Continued From page 12 Review on 6/18/24 of the facility's license revealed: - The facility was licensed for Supervised Living for Adults with Developmental Disabilities Review on 6/18/24 of a partial record for client #3 revealed: - Admitted 8/10/24 - Diagnoses of Schizoaffective Disorder, Type II Diabetes Mellitus, Hypothyroidism & Hyperlipidemia - No documentation of an Intellectual Developmental Disorder (IDD) diagnosis Review on 6/18/24 of client #5's record revealed: - Admitted 7/28/22 - Diagnoses of Schizoaffective Disorder, Hyperlipidemia, Type II Diabetes Mellitus & Tobacco Disorder - No documentation of an IDD diagnosis Interview on 6/18/24 the Qualified Professional (QP) reported: - The Administrator was responsible for reviewing clients' referrals and admitting clients into the facility - Client #3 was admitted on 8/10/24 - Didn't know if client #3 had a diagnosis of IDD - Thought client #5 had an IDD diagnosis - Couldn't find documentation showing client #6's IDD diagnosis Interviews on 6/18/24 & 7/22/24 the Administrator reported: - The facility was licensed to care for clients with developmental disabilities - Was responsible for reviewing clients' referrals and admitting clients into the facility	V 289		

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V 289	Continued From page 13 - Couldn't recall if client #3 had an IDD diagnosis - Moving forward she would involve the QP in the admission process	V 289		
V 366	27G .0603 Incident Response Requirements 10A NCAC 27G .0603 INCIDENT RESPONSE REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall develop and implement written policies governing their response to level I, II or III incidents. The policies shall require the provider to respond by: (1) attending to the health and safety needs of individuals involved in the incident; (2) determining the cause of the incident; (3) developing and implementing corrective measures according to provider specified timeframes not to exceed 45 days; (4) developing and implementing measures to prevent similar incidents according to provider specified timeframes not to exceed 45 days; (5) assigning person(s) to be responsible for implementation of the corrections and preventive measures; (6) adhering to confidentiality requirements set forth in G.S. 75, Article 2A, 10A NCAC 26B, 42 CFR Parts 2 and 3 and 45 CFR Parts 160 and 164; and (7) maintaining documentation regarding Subparagraphs (a)(1) through (a)(6) of this Rule. (b) In addition to the requirements set forth in 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	V 366	V 366 Incident Response Requirements The policy for incident report requirements was reviewed immediately by the administrator. An additional review was completed by the QP on 7/23/24. The review outlined and defined level 1, 2 and 3 incidents, reporting requirements and current procedures for incident reporting. The direct care staff is responsible for completing level 1 incidents and the QP is responsible for completing level 2 & 3 incidents. All incidents must be reported immediately to the QP or administrator when QP is not available. The administrator understands that any report involving injury, DSS, police, allegations of neglect, abuse or exploitation must be followed up on and reported to appropriate entities immediately or in the manner identified in the policies and procedures and/or regulations.	

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(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 366	Continued From page 14 develop and implement written policies governing their response to a level III incident that occurs while the provider is delivering a billable service or while the client is on the provider's premises. The policies shall require the provider to respond by: (1) immediately securing the client record by: (A) obtaining the client record; (B) making a photocopy; (C) certifying the copy's completeness; and (D) transferring the copy to an internal review team; (2) convening a meeting of an internal review team within 24 hours of the incident. The internal review team shall consist of individuals who were not involved in the incident and who were not responsible for the client's direct care or with direct professional oversight of the client's services at the time of the incident. The internal review team shall complete all of the activities as follows: (A) review the copy of the client record to determine the facts and causes of the incident and make recommendations for minimizing the occurrence of future incidents; (B) gather other information needed; (C) issue written preliminary findings of fact within five working days of the incident. The preliminary findings of fact shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different; and (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	V 366		

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	MHL092-859	A. BUILDING: _____ B. WING _____	R 07/22/2024

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V 366	Continued From page 15 identified by the internal review team, shall include all public documents pertinent to the incident, and shall make recommendations for minimizing the occurrence of future incidents. If all documents needed for the report are not available within three months of the incident, the LME may give the provider an extension of up to three months to submit the final report; and (3) immediately notifying the following: (A) the LME responsible for the catchment area where the services are provided pursuant to Rule .0604; (B) the LME where the client resides, if different; (C) the provider agency with responsibility for maintaining and updating the client's treatment plan, if different from the reporting provider; (D) the Department; (E) the client's legal guardian, as applicable; and (F) any other authorities required by law. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to convene a meeting of internal review within 24 hours of a level II incidents and failed to issue a written preliminary finding of fact to the Local Management Entity/Managed Care Organization (LME/MCO) within five working days of the incidents. The findings are: A. Review on 6/20/24 of client #1's hospital admission record dated 4/10/24 revealed:	V 366		

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V 366	Continued From page 16 - "Overnight she (client #1) had an unwitnessed fall. She was found on the floor. She was having right hip pain. X-rays in ER (Emergency Room) show a right femoral neck fracture." B. Review on 6/20/24 of a police report dated 6/6/24 revealed: - "This report is in regards to an Involuntary Commitment Service at 1238 Fairlane Rd...Suspect (Former Client (FC) #6) was committed involuntarily (IVC) at [local hospital]." Review on 6/18/24 of the facility's record revealed: - No documentation of an internal review meeting for client #1 or FC #6 - No documentation of a written preliminary finding of fact for client #1 or FC #6 Interviews on 6/18/24 & 6/20/24 the Qualified Professional (QP) reported: - Client #1 fell out of her bed and broke her right hip - Management used to hold meetings to discuss incidents, but they haven't done it in a long time - Was responsible for submitting written preliminary findings of fact within 5 days of the incident - The Administrator said that she had notified the LME/MCO but she "failed to follow up" - Was unaware of the incident involving FC #6 Interviews on 6/18/24 the Administrator reported: - Convened a meeting of internal review for client #1's hip fracture, but didn't convene a meeting for FC #6's IVC - "The QP should answer questions about [client #1]'s meeting" and notifying the LME/MCO	V 366		

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V 367	Continued From page 18 (1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or (2) the provider obtains information required on the incident form that was previously unavailable. (c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including: (1) hospital records including confidential information; (2) reports by other authorities; and (3) the provider's response to the incident. (d) Category A and B providers shall send a copy of all level III incident reports to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of becoming aware of the incident. Category A providers shall send a copy of all level III incidents involving a client death to the Division of Health Service Regulation within 72 hours of becoming aware of the incident. In cases of client death within seven days of use of seclusion or restraint, the provider shall report the death immediately, as required by 10A NCAC 26C .0300 and 10A NCAC 27E .0104(e)(18). (e) Category A and B providers shall send a report quarterly to the LME responsible for the catchment area where services are provided. 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;	V 367		

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V 367	Continued From page 19 (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 in the Incident Response Improvement System (IRIS) and notify the Local Management Entity/Managed Care Organization (LME/MCO) within 72 hours of becoming aware of an incident affecting 1 of 3 audited clients (#1) and 1 of 2 former clients (FC #6). The findings are: Review on 6/19/24 of the IRIS system revealed: - No IRIS report submitted for the following level II incidents: - 4/10/24: Client #1's hip fracture - 6/6/24: FC #6 was committed involuntarily A. Review on 6/18/24 of client #1's record revealed: - Admitted 12/1/15 - Diagnoses of Intellectual Developmental Disability (IDD), Arthritis, Hypertension, Hyperlipemia & Coronary Artery Disease Review on 6/20/24 of client #1's hospital	V 367		

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V 367	Continued From page 20 admission record dated 4/10/24 revealed: - "Overnight she (client #1) had an unwitnessed fall. She was found on the floor. She was having right hip pain. X-rays in ER (Emergency Room) show a right femoral neck fracture." Attempted interview on 6/18/24 with client #1 was unsuccessful because client #1 was hard of hearing and could not comprehend the questions asked. B. Review on 6/19/24 of FC #6's record revealed: - Admitted 6/5/24 and discharged 6/6/24 - Diagnoses of Posttraumatic Stress Disorder, IDD, Major Depression Disorder & Asthma Review on 6/19/24 of the facility's records revealed: - An incident report dated 6/6/24 written by the Licensee: "Ms. [FC #6]'s room mate complained that [FC #6] was using her phone and wanted it back. I (Administrator) went back to her room and asked her to give the phone back to her room mate. She became very upset and started yelling...I... reminded her that her guardian had (ineligible) against her using the phone due to an incident that happened between her and her boyfriend. She got very upset and jumped from her bed and charged towards me aggressively. I managed to escape and she tried to hit me. I called 911..." Review on 6/20/24 of a police report dated 6/6/24 revealed: - "This report is in regards to an Involuntary Commitment Service at 1238 Fairlane Rd...Suspect (Former Client (FC) #6) was committed involuntarily (IVC'd) at [local hospital]."	V 367		

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V 367	Continued From page 21 Interview on 6/20/24 FC #6 reported: - Had an altercation with the Administrator on 6/6/24 - The Administrator called the police and she was IVC'd Interviews on 6/18/24 and 6/20/24 the Qualified Professional (QP) reported: - Was responsible for ensuring IRIS reports were completed - The Administrator stated that she completed the IRIS report for client #1's fractured hip, but she "failed to follow-up" to ensure the IRIS report was completed - Was unaware of the incident that occurred between the Licensee and FC #6 Interviews on 6/18/24 & 7/22/24 the Administrator reported: - The QP was responsible for ensuring IRIS reports were completed - Wasn't aware the QP didn't submit an IRIS for client #1's hip fracture - The QP should have completed an IRIS report for client #1's hip fracture - The QP was unaware of the incident involving FC #6 - Notifying the QP and LME/MCO of the incident involving FC #6 "skipped" her memory	V 367		
V 736	27G .0303(c) Facility and Grounds Maintenance 10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS (c) Each facility and its grounds shall be maintained in a safe, clean, attractive and orderly manner and shall be kept free from offensive odor.	V 736	V 736 – Facility Grounds and Maintenance. The facility administrator has started the process of making repairs and painting specific areas in the group home. Going forward the administrator will complete monthly inspections in the home and will make necessary repairs or modifications within a timely manner. Additionally, the QP will inspect at least quarterly and advise the administrator that repairs are needed. This will be monitored by QP at least quarterly.	

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V 736	Continued From page 22 This Rule is not met as evidenced by: Based on observation and interview, the facility was not maintained in a safe, clean and attractive manner. The findings are: Observation on 6/18/24 at approximately 10:10am revealed: - Ceiling around the fireplace had a brown stain the approximately 5 feet long with paint peeling off in multiple places - The hallway bathroom had dime sized black stains around the bathtub sealant - The trim around the bathtub was coming away from the wall and had been taped - The paint behind the hallway bathroom door had an area approximately 10 inches by 6 inches with peeling and bubbling paint - The wood on the front door was chipped, exposing the latch of the doorknob - The ceiling in client #5's bathroom had black stains covering half of the ceiling - The double sliding closet doors in client #2 and client #4's bedroom was off the track and leaned against the wall - The vent in the hallway was rusted and dirty Interview on 6/18/24 the Qualified Professional reported: - The Licensee was responsible for repairs to the facility Interview on 7/22/24 the Administrator reported: - Planned to have the repairs to the facility completed by next month - Needs to have the repairs completed to "pass inspection" in September 2024 This deficiency has been cited 6 times since the original cite on 5/23/22 and must be corrected within 30 days.	V 736		

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