STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL026-761	A. BUILDING: _____ B. WING _____	R-C 11/26/2024

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THE LOVING HOME, INC	4944 MACEDONIA CHURCH ROAD FAYETTEVILLE, NC 28312

(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 A complaint and follow up survey was completed on November 26, 2024. The complaints were substantiated (intake #NC00223482, #NC00223571 and #NC00223638). 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 3 and has a current census of 1. The survey sample consisted of audits of 1 current client 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;	V 105		

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V 105	Continued From page 1 (B) an assessment of whether or not the facility 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, observation and interviews, the facility failed to develop and implement written policies for delegation of management authority, admission screening and assessments to determine if the facility could meet the needs of the client for 1 of 1 current client (#1) and 1 of 1 Former Client (FC #2). The findings are:

Finding #1
Observation on 11/14/24 between 9:30am - 11:30am of the facility revealed no one was present at the facility.

Interview on 11/14/24 the Interim Director stated:
-No staff was available to begin the survey.
-She was not available and was out of town.
-The facility did not have any staff.
-There was one client (client #1) admitted to the facility who was hospitalized.
-The hospitalized client #1 would be discharged from the hospital to a sister facility.
-The Staff/Client Administrator was the only person with a key to the facility.
-The Staff/Client Administrator was not available.
-There was no one available at the Licensee/Qualified Professional's [L/QP] office to begin the survey.
-She reached out to the L/QP and had not received a response.

Attempted interview on 11/14/24 with the L/QP resulted in a phone call and voicemail message

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V 105	Continued From page 3 to request a returned call and a text message to inform of the initiation of the survey process. Interview on 11/26/24 the Licensee/Qualified Professional stated: -She was informed by the Interim Director on 11/14/24 the survey would began on 11/15/24. -She was available for survey on 11/14/24. Finding #2 Review on 11/15/24 of client #1's record revealed: -Unknown admission date. -Diagnoses of Moderate Intellectual Disability and Intermittent Explosive Disorder. -No documentation of an admission screening or assessment of the client's needs. Review on 11/15/24 of Former Client #2's record revealed: -Unknown admission date. -Diagnosis of Mild Intellectual Disability. -No documentation of an admission screening or assessment of the client's needs. Interview on 11/26/24 the L/QP stated: -The policy manual was not available for review. -The facility's policies were being updated by a consultant. -The facility did not have access to their policies. -The Interim Director and Staff/Client Administrator were responsible for the admission screening and assessment. This deficiency is cross referenced into 10A NCAC 27G .5601 Scope (V289) for a Type B rule violation and must be corrected within 45 days.	V 105		
V 107	27G .0202 (A-E) Personnel Requirements	V 107		

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V 107	Continued From page 4 10A NCAC 27G .0202 PERSONNEL REQUIREMENTS (a) All facilities shall have a written job description for the director and each staff position which: (1) specifies the minimum level of education, competency, work experience and other qualifications for the position; (2) specifies the duties and responsibilities of the position; (3) is signed by the staff member and the supervisor; and (4) is retained in the staff member's file. (b) All facilities shall ensure that the director, each staff member or any other person who provides care or services to clients on behalf of the facility: (1) is at least 18 years of age; (2) is able to read, write, understand and follow directions; (3) meets the minimum level of education, competency, work experience, skills and other qualifications for the position; and (4) has no substantiated findings of abuse or neglect listed on the North Carolina Health Care Personnel Registry. (c) All facilities or services shall require that all applicants for employment disclose any criminal conviction. The impact of this information on a decision regarding employment shall be based upon the offense in relationship to the job for which the applicant is applying. (d) Staff of a facility or a service shall be currently licensed, registered or certified in accordance with applicable state laws for the services provided. (e) A file shall be maintained for each individual employed indicating the training, experience and other qualifications for the position, including	V 107		

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V 107	Continued From page 5 verification of licensure, registration or certification. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to have complete personnel records affecting 1 of 2 audited Former Staff (FS) (#1) and 3 of 3 current staff (Staff/Client Administrator, Interim Director and Licensee/Qualified Professional (L/QP)). The findings are: Review on 11/15/24 of FS #1's personnel record revealed: -Hire Date: 12/3/11. -Job Title: Paraprofessional -No documentation of a job description or termination date. Review on 11/18/24 of the Staff/Client Administrator's personnel record revealed: -Hire Date: Unknown. -No signed job description. Review on 11/18/24 of the Interim Director's personnel record revealed: -Hire Date: Unknown. -No signed job description. Review on 11/18/24 of the L/QP's personnel record revealed: -Paraprofessional job description signed 7/5/06. -No signed job description as the Qualified	V 107		

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V 107	Continued From page 6 Professional. Interview on 11/18/24 FS #1 stated: -She had worked at the facility for 10-14 years. -She worked as the Group Home Manager until May or June 2024 when Management changed. She continued the same duties without the Group Home Manager title. Interview on 11/18/24 the Staff/Client Administrator stated: -She worked at the facility since May/June 2024. -There was a joint effort between her and the Interim Director to ensure personnel files were maintained. -The personnel files were kept locked by the Interim Director. -She had not check the personnel files in the last 30 days. Interview on 11/26/24 the Staff/Client Administrator stated: -She was unable to locate any staff personnel records. -The staff personnel records were not at the office for review. Interview on 11/15/24 and 11/18/24 the Interim Director stated: -She worked at the facility since May 2024 -The employee files were missing information. -She was unsure where the information went. -The employee files had all documentation and were complete to include signed job descriptions within the last month and provided for an audit. -The Staff/Client Administrator was responsible for maintaining the employee files. Interview on 11/26/24 the L/QP stated: -She was informed by the Interim Director the	V 107		

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V 107	Continued From page 7 staff personnel records were missing when requested for survey. -She had attempted to locate the staff personnel records. -She was unaware staff personnel records were reviewed during survey. -She had not located any staff personnel records. This deficiency constitutes a re-cited deficiency. This deficiency is cross referenced into 10A NCAC 27G .5601 Scope (V289) for a Type B rule violation and must be corrected within 45 days.	V 107		
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	V 108		

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V 108	Continued From page 8 techniques such as those provided by Red Cross, 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 interviews, the facility failed to ensure 1 of 2 audited Former Staff (FS) (#1) were currently trained in Cardiopulmonary Resuscitation (CPR) and First Aid. The findings are: Review on 11/15/24 of FS #1's personnel record revealed: -Hire Date: 12/3/11. -Job Title: Paraprofessional. -No documentation of a certification in CPR/First Aid. Interview on 11/19/24 FS #1 stated: -She was trained in CPR/First Aid. -She worked her shift alone. Interview on 11/18/24 the Licensee/Qualified Professional stated: -All staff were trained in CPR/First Aid by an outside trainer. -The personnel records could not be located. This deficiency constitutes a re-cited deficiency.	V 108		

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V 108	Continued From page 9 This deficiency is cross referenced into 10A NCAC 27G .5601 Scope (V289) for a Type B rule violation and must be corrected within 45 days.	V 108		
V 109	27G .0203 Privileging/Training Professionals 10A NCAC 27G .0203 COMPETENCIES OF QUALIFIED PROFESSIONALS AND ASSOCIATE PROFESSIONALS (a) There shall be no privileging requirements for qualified professionals or associate professionals. (b) Qualified professionals and associate professionals shall demonstrate knowledge, skills and abilities required by the population served. (c) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence. (d) 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. (e) Qualified professionals as specified in 10A NCAC 27G .0104 (18)(a) are deemed to have met the requirements of the competency-based employment system in the State Plan for MH/DD/SAS. (f) The governing body for each facility shall develop and implement policies and procedures for the initiation of an individualized supervision plan upon hiring each associate professional. (g) The associate professional shall be supervised by a qualified professional with the population served for the period of time as	V 109		

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V 109	Continued From page 10 specified in Rule .0104 of this Subchapter. This Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure one of one Licensee/Qualified Professional (L/QP) demonstrated knowledge, skills and abilities. The findings are: Review on 11/15/24 of the L/QP's personnel record revealed: -No Date of Hire. -No signed job description as the QP. -Paraprofessional job description signed 7/5/06. Interview on 11/18/24 the L/QP stated: -She was the QP for the facility. -The previous QP left the facility a few months ago. -She had not visited the facility a lot due to driving being difficult as she relies on a walker for mobility. -She had not been to the facility in the last 3 months. -The Interim Director and Staff/Client Administrator would know about the clients' treatment plans. -She did not have any knowledge of the clients' medical history as the Interim Director and Staff/Client Administrator took care of it. -The previous QP handled the personnel records. The Interim Director handled the personnel records she "just really signed until she gets better" however she asks "questions and wants updates."	V 109		

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V 109	Continued From page 11 -She was "upset" when she learned the personnel files were "empty" and not complete. -The facility had outside trainers to train staff in Nonviolent Crisis Intervention and cardiopulmonary resuscitation/first aid. -She had not provided any trainings to staff. -She provided supervision "sometimes I go there or call" staff "from time to time." -Incident Reporting was Interim Director and Staff/Client Administrator responsibility. -She had not reported the allegation of abuse against Former Staff (FS) #1 and #2. -She had not completed an internal investigation regarding the allegation of abuse against FS #1 and #2. This deficiency is cross referenced into 10A NCAC 27G .5601 Scope (V289) for a Type B rule violation and must be corrected within 45 days.	V 109		
V 111	27G .0205 (A-B) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (a) An assessment shall be completed for a client, according to governing body policy, prior to the delivery of services, and shall include, but not be limited to: (1) the client's presenting problem; (2) the client's needs and strengths; (3) a provisional or admitting diagnosis with an established diagnosis determined within 30 days of admission, except that a client admitted to a detoxification or other 24-hour medical program shall have an established diagnosis upon admission; (4) a pertinent social, family, and medical history;	V 111		

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V 111	Continued From page 12 and (5) evaluations or assessments, such as psychiatric, substance abuse, medical, and vocational, as appropriate to the client's needs. (b) When services are provided prior to the establishment and implementation of the treatment/habilitation or service plan, hereafter referred to as the "plan," strategies to address the client's presenting problem shall be documented. This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to provide documentation that a completed admission assessment was completed prior to the delivery of services for one of one current clients (#1) and one of one former client (FC) (#2). The findings are: Review on 11/15/24 of client #1's record revealed: -49 year old male. -Unknown admission date. -Diagnoses of Moderate Intellectual Disability and Intermittent Explosive Disorder. -No documentation of an admission assessment or admission screening. Review on 11/15/24 of FC #2's record revealed: -45 year old female. -Unknown admission date.	V 111		

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V 111	Continued From page 13 -Diagnosis of Mild Intellectual Disability. -No documentation of an admission assessment or admission screening. Interview on 11/26/24 the Licensee/Qualified Professional stated: -The admission assessment should have been completed by the Interim Director. -She was unsure when client #1 and FC #2 were admitted to the facility. -The facility did not have an admission assessment for client #1 and FC #2. This deficiency constitutes a re-cited deficiency. This deficiency is cross referenced into 10A NCAC 27G .5601 Scope (V289) for a Type B rule violation and must be corrected within 45 days.	V 111		
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; (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	V 113		

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V 113	Continued From page 14 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 records review and interview, the facility failed to ensure records were complete for one of one current client (#1) and one of one former client (FC) (#2). The findings are: Review on 11/15/24 of client #1's record revealed: -Unknown admission date. -Diagnoses of Moderate Intellectual Disability and Intermittent Explosive Disorder. -No evidence of a signed current treatment plan,	V 113		

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	MHL026-761	A. BUILDING: _____ B. WING _____	R-C 11/26/2024

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medication administration records (MAR) for August, September or October 2024, or medical records for recent medical visits.

Review on 11/15/24 of FC #2's record revealed:
-Unknown admission date.
-Diagnosis of Mild Intellectual Disability.
-No documentation of MARs for August, September or October 2024, signed physicians orders and no documentation of a discharge summary.

Interview on 11/19/24 client #1's legal guardian stated:
-She received a call from client #1's medical provider requesting permission to release client #1's medical records to Former Staff (FS) #1.
-The Interim Director had informed her FS #1 no longer worked at the facility.

Interview on 11/18/24 the Staff/Client Administrator stated:
-She had a list of items she was provided by the Interim Director to see if she could locate the items.

Interview on 11/26/24 the Staff/Client Administrator stated:
-She attempted to locate the additional client records and was unsuccessful.
-The MARs were maintained in a separate book and she had not located it.
-The clients medical records were maintained in a separate book and she had not located it.
-The medical providers were familiar with FS #1 so she requested FS #1 gather medical records.

Interview on 11/15/24 and 11/18/24 the Interim Director stated:
-She was unable to locate client #1's treatment

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V 113	Continued From page 16 plan or the MARs which were requested. -The Staff/Client Administrator was responsible to ensure information was in the client record's. -She emailed the Staff/Client Administrator about this request. Interview on 11/26/24 the Licensee/Qualified Professional stated: -She hired a locksmith to unlock the cabinets in an attempt to locate records. -She requested FS #1 go to client #1's medical providers and gather records for survey. This deficiency constitutes a re-cited deficiency. This deficiency is cross referenced into 10A NCAC 27G .5601 Scope (V289) for a Type B rule violation and must be corrected within 45 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	V 118		

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V 118	Continued From page 17 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 interviews, the facility 1) failed to ensure staff who administer medications were licensed persons, or unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person to administer medications, effecting 1 of 2 Former Staff (FS #1) and; 2) failed to keep the MARs current for one of one current client (#1) and one of one former client (FC #2). The findings are: Finding #1 Review on 11/15/24 of FS #1's personnel record revealed: -Hire Date: 12/3/11. -No documentation of termination date provided. -Job Title: Paraprofessional -No documentation of a medication administration training. Interview on 11/19/24 FS #1 stated:	V 118		

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V 118	Continued From page 18 -She worked at the facility 10-14 years. -She was trained in medication administration. -She administered medications to the clients. Finding #2 Review on 11/15/24 of client #1's record revealed: -Unknown admission date. -Diagnoses of Moderate Intellectual Disability and Intermittent Explosive Disorder. -No documentation of MARs from August - October 2024. Review on 11/26/24 of client #1's signed physician orders dated 10/2/23 revealed: -Benztropine 2 milligram (mg) twice daily. (Anti-Tremor) -Clonidine 0.1 mg daily. (Attention Deficit Hyperactivity Disorderly) -Topiramate 50 mg daily. (Bipolar) -Olanzapine 15 mg twice daily. (Bipolar) -Dairy Relief 3000 unit as needed. (Lactose Intolerance) -Divalproex 500 twice daily. (Bipolar) -Latanoprost 0.005% eye drops daily. (Glaucoma) -Trazadone 100 mg daily. (Depression) -Levothyroxine 50 micrograms daily. (Hypothyroidism) -Acetaminophen 325 mg as needed. (Pain) -Tamsulosin 0.4 mg daily. (Enlarged Prostate) -Omeprazole 20 mg daily. (Heartburn) -Polyethylene Glycol 3350 daily. (Constipation) Attempted on 11/18/24 to interview client #1 was unsuccessful as he was hospitalized and unable to respond to questions. Interview on 11/15/24 client #1's legal guardian stated: -Client #1 had not had a medication change.	V 118		

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V 118	Continued From page 19 Review on 11/15/24 of FC #2's record revealed: -Unknown admission date. -Diagnosis of Mild Intellectual Disability. -No documentation of MARs from August - October 2024 or current signed physician orders. Review on 11/18/24 of a local pharmacy "Facility Delivery Log" dated 9/12/24 revealed the following medications for FC #2: -Quetiapine Fumarate 400 mg (Schizophrenia) -Haloperidol 5 mg (Schizophrenia) -Benztropine 1 mg -Omeprazole 20 mg -Medroxyprogesterone 150 mg (Birth Control) -Aspirin 81 mg (Pain) -Loratadine 10 mg (Allergy) -Docusate Sodium 100 mg (Stool Softener) -Metformin 500 mg (Diabetes) -Calcium 600 mg and Vitamin D3 (Supplement) -Latanoprost 0.005% Eye Drops -Lamotrigine 100 mg (Bipolar) Interview on 11/20/24 FC #2 stated: -She received her medications as ordered. Interview on 11/19/24 FS #1 stated: -She reviewed the MARs and checked the medications. -The clients received their medications as ordered. Interview on 11/26/24 the Staff/Client Administrator stated: -The clients' signed physician orders and MARs were kept in individual client records at the facility. -The client records could not be located for survey. This deficiency is cross referenced into 10A	V 118		

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V 118	Continued From page 20 NCAC 27G .5601 Scope (V289) for a Type B rule violation and must be corrected within 45 days. .	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 reviews and interviews, the facility failed to ensure the Health Care Personnel Registry (HCPR) was accessed prior to employment for 1 of 2 audited former staff (FS) (#1). The findings are: Review on 11/15/24 of FS #1's personnel record revealed: -Hire Date: 12/3/11. -No documentation HCPR was accessed prior to hire. Interview on 11/15/24 FS #1 stated: -She worked at the facility for 10-14 years.	V 131		

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V 131	Continued From page 21 Interview on 11/26/24 the Licensee/Qualified Professional stated: -She had not located the facility's personnel files. -The facility had a complete personnel file for FS #1 and HCPR had been accessed for FS #1. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 131		
V 132	G.S. 131E-256(G) HCPR-Notification, Allegations, & Protection G.S. §131E-256 HEALTH CARE PERSONNEL REGISTRY (g) Health care facilities shall ensure that the Department is notified of all allegations against health care personnel, including injuries of unknown source, which appear to be related to any act listed in subdivision (a)(1) of this section. (which includes: a. Neglect or abuse of a resident in a healthcare facility or a person to whom home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided. b. Misappropriation of the property of a resident in a health care facility, as defined in subsection (b) of this section including places where home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided. c. Misappropriation of the property of a healthcare facility. d. Diversion of drugs belonging to a health care facility or to a patient or client. e. Fraud against a health care facility or against a patient or client for whom the employee is providing services). Facilities must have evidence that all alleged acts are investigated and must make every effort	V 132		

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V 132	Continued From page 22 to protect residents from harm while the investigation is in progress. The results of all investigations must be reported to the Department within five working days of the initial notification to the Department. This Rule is not met as evidenced by: Based on record reviews and interview, the facility failed to ensure that the Health Care Personnel Registry (HCPR) was notified of allegations against facility staff and provide evidence that the allegation was investigated affecting 2 of 2 former staff (FS #1 and FS #2). The findings are: Review on 11/15/24 and 11/26/24 of the facility's records revealed: -No documentation the HCPR was notified of an allegation of abuse against FS #1 and FS #2 on approximately 10/31/24. -No documentation an investigation was completed and submitted to HCPR within 5 working days subsequent to allegations of abuse against FS #1 and FS #2 on approximately 10/31/24. Review on 11/15/24 of client #1's record revealed: -49 year old male. -Unknown admission date. -Diagnoses of Moderate Intellectual Disability and Intermittent Explosive Disorder. Review on 11/15/24 of FS #1's personnel record revealed: -Hire Date: 12/3/11. -No date of termination provided. -Job Title: Direct Care Staff. Review on 11/15/24 of FS #2's personnel record revealed:	V 132		

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V 132	Continued From page 23 -Hire Date: 12/30/09. -No date of termination provided. -Job Title: Direct Care Staff. Interview on 11/19/24 client #1's legal guardian stated: -She received a call on 11/19/24 from the Interim Director who played a audio recording (phone) for her. -On the audio recording, Former Client (FC) #2 told the Interim Director she saw FS#1 and FS #2 drag client #1 down the hall. FS #1 grabbed client #1's shirt and started hitting him. The Licensee/Qualified Professional (L/QP) told FC #2 "don't you lie" and the camera would have caught it. The L/QP would have FC #2 in front of FS #1 and FS #2 to see if she would repeat allegations. Interview on 11/20/24 Former Client #2 stated: -FS#1 took client #1 by his shirt and dragged him on the floor. -It happened several times but could not remember when. -She told the Interim Director about the incident before she left (11/1/24). Interview on 11/19/24 FS #1 stated: -She was not aware of any allegations made against her. -She had not pushed or dragged client #1. -She had not witness client #1 or Former Client #2 mistreated. Attempted interview on 11/15/24 and 11/18/24 with FS #2 was unsuccessful as calls or text messages were not returned. Interview on 11/26/24 the L/QP stated: -The Interim Director informed her of the	V 132		

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V 132	Continued From page 24 allegations on 10/31/24 made against FS #1 and FS #2. -She requested the Interim Director bring FC #2 to see her. -FC #2 alleged she saw FS #1 and FS #2 hit and drag client #1. -She told FC #2 she (FC #2) would need to "say it to staff" FS #1 and FS #2 of the allegations against them. -FC #2 had "lied a lot." -She had not completed an internal investigation or made a report to HCPR because she "did not take it serious." This deficiency is cross referenced into 10A NCAC 27G .5601 Scope (V289) for a Type B rule violation and must be corrected within 45 days.	V 132		
V 133	G.S. 122C-80 Criminal History Record Check G.S. §122C-80 CRIMINAL HISTORY RECORD CHECK REQUIRED FOR CERTAIN APPLICANTS FOR EMPLOYMENT. (a) Definition. - As used in this section, the term "provider" applies to an area authority/county program and any provider of mental health, developmental disability, and substance abuse services that is licensable under Article 2 of this Chapter. (b) Requirement. - An offer of employment by a provider licensed under this Chapter to an applicant to fill a position that does not require the applicant to have an occupational license is conditioned on consent to a State and national criminal history record check of the applicant. If the applicant has been a resident of this State for less than five years, then the offer of employment is conditioned on consent to a State and national criminal history record check of the applicant. The	V 133		

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V 133	Continued From page 25 national criminal history record check shall include a check of the applicant's fingerprints. If the applicant has been a resident of this State for five years or more, then the offer is conditioned on consent to a State criminal history record check of the applicant. A provider shall not employ an applicant who refuses to consent to a criminal history record check required by this section. Except as otherwise provided in this subsection, within five business days of making the conditional offer of employment, a provider shall submit a request to the Department of Justice under G.S. 114-19.10 to conduct a criminal history record check required by this section or shall submit a request to a private entity to conduct a State criminal history record check required by this section. Notwithstanding G.S. 114-19.10, the Department of Justice shall return the results of national criminal history record checks for employment positions not covered by Public Law 105-277 to the Department of Health and Human Services, Criminal Records Check Unit. Within five business days of receipt of the national criminal history of the person, the Department of Health and Human Services, Criminal Records Check Unit, shall notify the provider as to whether the information received may affect the employability of the applicant. In no case shall the results of the national criminal history record check be shared with the provider. Providers shall make available upon request verification that a criminal history check has been completed on any staff covered by this section. A county that has adopted an appropriate local ordinance and has access to the Division of Criminal Information data bank may conduct on behalf of a provider a State criminal history record check required by this section without the provider having to submit a	V 133		

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V 133	Continued From page 26	V 133		

request to the Department of Justice. In such a case, the county shall commence with the State criminal history record check required by this section within five business days of the conditional offer of employment by the provider. All criminal history information received by the provider is confidential and may not be disclosed, except to the applicant as provided in subsection (c) of this section. For purposes of this subsection, the term "private entity" means a business regularly engaged in conducting criminal history record checks utilizing public records obtained from a State agency.
(c) Action. - If an applicant's criminal history record check reveals one or more convictions of a relevant offense, the provider shall consider all of the following factors in determining whether to hire the applicant:
(1) The level and seriousness of the crime.
(2) The date of the crime.
(3) The age of the person at the time of the conviction.
(4) The circumstances surrounding the commission of the crime, if known.
(5) The nexus between the criminal conduct of the person and the job duties of the position to be filled.
(6) The prison, jail, probation, parole, rehabilitation, and employment records of the person since the date the crime was committed.
(7) The subsequent commission by the person of a relevant offense.
The fact of conviction of a relevant offense alone shall not be a bar to employment; however, the listed factors shall be considered by the provider. If the provider disqualifies an applicant after consideration of the relevant factors, then the provider may disclose information contained in the criminal history record check that is relevant

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to the disqualification, but may not provide a copy of the criminal history record check to the applicant.
(d) Limited Immunity. - A provider and an officer or employee of a provider that, in good faith, complies with this section shall be immune from civil liability for:
(1) The failure of the provider to employ an individual on the basis of information provided in the criminal history record check of the individual.
(2) Failure to check an employee's history of criminal offenses if the employee's criminal history record check is requested and received in compliance with this section.
(e) Relevant Offense. - As used in this section, "relevant offense" means a county, state, or federal criminal history of conviction or pending indictment of a crime, whether a misdemeanor or felony, that bears upon an individual's fitness to have responsibility for the safety and well-being of persons needing mental health, developmental disabilities, or substance abuse services. These crimes include the criminal offenses set forth in any of the following Articles of Chapter 14 of the General Statutes: Article 5, Counterfeiting and Issuing Monetary Substitutes; Article 5A, Endangering Executive and Legislative Officers; Article 6, Homicide; Article 7A, Rape and Other Sex Offenses; Article 8, Assaults; Article 10, Kidnapping and Abduction; Article 13, Malicious Injury or Damage by Use of Explosive or Incendiary Device or Material; Article 14, Burglary and Other Housebreakings; Article 15, Arson and Other Burnings; Article 16, Larceny; Article 17, Robbery; Article 18, Embezzlement; Article 19, False Pretenses and Cheats; Article 19A, Obtaining Property or Services by False or Fraudulent Use of Credit Device or Other Means; Article 19B, Financial Transaction Card Crime

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V 133	Continued From page 28 Act; Article 20, Frauds; Article 21, Forgery; Article 26, Offenses Against Public Morality and Decency; Article 26A, Adult Establishments; Article 27, Prostitution; Article 28, Perjury; Article 29, Bribery; Article 31, Misconduct in Public Office; Article 35, Offenses Against the Public Peace; Article 36A, Riots and Civil Disorders; Article 39, Protection of Minors; Article 40, Protection of the Family; Article 59, Public Intoxication; and Article 60, Computer-Related Crime. These crimes also include possession or sale of drugs in violation of the North Carolina Controlled Substances Act, Article 5 of Chapter 90 of the General Statutes, and alcohol-related offenses such as sale to underage persons in violation of G.S. 18B-302 or driving while impaired in violation of G.S. 20-138.1 through G.S. 20-138.5. (f) Penalty for Furnishing False Information. - Any applicant for employment who willfully furnishes, supplies, or otherwise gives false information on an employment application that is the basis for a criminal history record check under this section shall be guilty of a Class A1 misdemeanor. (g) Conditional Employment. - A provider may employ an applicant conditionally prior to obtaining the results of a criminal history record check regarding the applicant if both of the following requirements are met: (1) The provider shall not employ an applicant prior to obtaining the applicant's consent for criminal history record check as required in subsection (b) of this section or the completed fingerprint cards as required in G.S. 114-19.10. (2) The provider shall submit the request for a criminal history record check not later than five business days after the individual begins conditional employment. (2000-154, s. 4; 2001-155, s. 1; 2004-124, ss. 10.19D(c), (h);	V 133		

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V 133	Continued From page 29 2005-4, ss. 1, 2, 3, 4, 5(a); 2007-444, s. 3.) This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure the criminal history record check was requested within five business days of making the conditional offer of employment affecting one of two audited Former Staff (FS #1). The findings are: Review on 11/15/24 of FS #1's personnel record revealed: -Hire Date: 12/3/11. -No date of termination provided. -No documentation of a criminal record check. Interview on 11/15/24 FS #1 stated: -She worked at the facility for 10-14 years. Interview on 11/26/24 the Licensee/Qualified Professional stated: -She had not located the facility's personnel files. -The facility had a complete personnel file for FS #1. -A criminal record check was completed for FS #1. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 133		
V 289	27G .5601 Supervised Living - Scope 10A NCAC 27G .5601 SCOPE (a) Supervised living is a 24-hour facility which	V 289		

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V 289	Continued From page 30 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 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	V 289		

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V 289	Continued From page 31 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 reviews, observation and interviews the facility failed to operate within its scope for one of one current client (#1) and one of one Former Client (FC) (#2). The findings are: Cross Reference: 10A NCAC 27G .0201 GOVERNING BODY POLICIES (V105) Based on record review, observation and interviews, the facility failed to develop and implement written policies for delegation of management authority, admission screening and assessments to determine if the facility could meet the needs of the client for 1 of 1 current client (#1) and 1 of 1 Former Client (FC #2). Cross Reference: 10A NCAC 27G .0202	V 289		

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V 289	Continued From page 32 PERSONNEL REQUIREMENTS (V107) Based on record review and interview, the facility failed to have complete personnel records affecting 1 of 2 audited Former Staff (FS) (#1) and 3 of 3 current staff (Staff/Client Administrator, Interim Director and Licensee/Qualified Professional (L/QP)). Cross Reference: 10A NCAC 27G .0202 PERSONNEL REQUIREMENTS (V108) Based on record review and interviews, the facility failed to ensure 1 of 2 audited Former Staff (FS) (#1) were currently trained in Cardiopulmonary Resuscitation (CPR) and First Aid. Cross Reference: 10A NCAC 27G .0203 COMPETENCIES OF QUALIFIED PROFESSIONALS AND ASSOCIATE PROFESSIONALS (V109) Based on record review and interview the facility failed to ensure one of one Licensee/Qualified Professional (L/QP) demonstrated knowledge, skills and abilities. Cross Reference: 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (V111) Based on record reviews and interviews the facility failed to provide documentation that a completed admission assessment was completed prior to the delivery of services for one of one current clients (#1) and one of one former client (FC) (#2). Cross Reference: 10A NCAC 27G .0206 CLIENT RECORDS (V113) Based on records review and interview, the facility failed to ensure records were complete for one of one current client (#1) and one of one former client (FC) (#2).	V 289		

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V 289	Continued From page 33 Cross Reference: 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (V118) Based on record review and interviews, the facility 1) failed to ensure staff who administer medications were licensed persons, or unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person to administer medications, effecting 1 of 2 Former Staff (FS #1) and; 2) failed to keep the MARs current for one of one current client (#1) and one of one former client (FC #2). Cross Reference: G.S. 131E-256 HEALTH CARE PERSONNEL REGISTRY (V132) Based on record reviews and interview, the facility failed to ensure that the Health Care Personnel Registry (HCPR) was notified of allegations against facility staff and provide evidence that the allegation was investigated affecting 2 of 2 former staff (FS #1 and #2). Cross Reference: 10A NCAC 27G .0603 INCIDENT RESPONSE REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (V366) Based on record reviews and interviews, the facility failed to implement written policies governing their response to incidents as required. Cross Reference: 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (V367) Based on record reviews and interviews, the facility failed to ensure an incident report was submitted to the Local Management Entity/Managed Care Organization (LME/MCO) within 72 hours as required. Cross Reference: 10A NCAC 27D .0101 POLICY ON RIGHTS RESTRICTIONS AND INTERVENTIONS (V500) Based on record	V 289		

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V 289	Continued From page 34 reviews and interviews, the facility failed to ensure all instances of alleged or suspected abuse, neglect or exploitation were reported to the county department of social services (DSS). Cross Reference: 10A NCAC 27E .0107 TRAINING ON ALTERNATIVES TO RESTRICTIVE INTERVENTIONS (V536) Based on record reviews and interviews, the facility failed to ensure current training in alternatives to restrictive interventions for one of two audited former staff (FS #1). Cross Reference: 10A NCAC 27E .0108 TRAINING IN SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT (V537) Based on record review and interview the facility failed to ensure one of two audited former staff (FS #1) were trained in restrictive interventions. Review on 11/26/24 of a Plan of Protection completed by the Staff/Client Administrator revealed: -"What immediate action will the facility take to ensure the safety of the consumers in your care? 1. All personnel will complete training and All paperwork Before starting work at Homes (facilities). 2. The Loving Home (The Loving Home, Inc.) QP will have all of her/his Qualifications on file. QP will supervise and follow up. 3. Incident Reporting will be Report immediately and All state protocols will be followed. -Describe your plans to make sure the above happens. Contracted QP will complete all Trng (Training) and Paperwork Before New Hire Starts Working. QP will complete Bi-Weekly check on Homes (facilities), Records, Clients and Staff. QP w/ (with) Ensure all Records are up to Date. QP will complete IRIS Report and Check Information	V 289		

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V 289	Continued From page 35 daily." The facility served clients with diagnoses of Intellectual Disability Disorder and Intermittent Explosive Disorder. The facility failed to follow their policy for the delegation of management authority which resulted in a one day delay of the onsite survey. The L/QP responsible for the training and supervision of direct care staff and oversight of the facility had no knowledge of the client's treatment or medical needs. The L/QP delegated responsibility to the Interim Director and Staff/Client Administrator but had not followed up to ensure the facility operations were maintained which included; former staff #1 did not have a personnel record or a signed job description, CPR/First Aid Certification, HCPR, criminal records checks, training in alternatives to restrictive interventions and restrictive interventions training. The L/QP, Interim Director and Staff/Client Administrator had not maintained documentation for incident reports or reported to the LME/MCO for an allegation of abuse against former staff #1 and #2. The L/QP, Interim Director and Staff/Client Administrator were responsible for the operations of the supervised living facility. Client records were incomplete for admission assessments, MARs, physician orders and treatment plans and incidents were not documented and allegations not reported as required; therefore, a systemic failure occurred and staff records were not maintained as required. This deficiency constitutes a Type B rule violation which is detrimental to the health, safety and welfare of the clients and must be corrected	V 289		

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V 289	Continued From page 36 within 45 days.	V 289		
V 291	27G .5603 Supervised Living - Operations 10A NCAC 27G .5603 OPERATIONS (a) Capacity. A facility shall serve no more than six clients when the clients have mental illness or developmental disabilities. Any facility licensed on June 15, 2001, and providing services to more than six clients at that time, may continue to provide services at no more than the facility's licensed capacity. (b) Service Coordination. Coordination shall be maintained between the facility operator and the qualified professionals who are responsible for treatment/habilitation or case management. (c) Participation of the Family or Legally Responsible Person. Each client shall be provided the opportunity to maintain an ongoing relationship with her or his family through such means as visits to the facility and visits outside the facility. Reports shall be submitted at least annually to the parent of a minor resident, or the legally responsible person of an adult resident. Reports may be in writing or take the form of a conference and shall focus on the client's progress toward meeting individual goals. (d) Program Activities. Each client shall have activity opportunities based on her/his choices, needs and the treatment/habilitation plan. Activities shall be designed to foster community inclusion. Choices may be limited when the court or legal system is involved or when health or safety issues become a primary concern. This Rule is not met as evidenced by:	V 291		

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V 291	Continued From page 37 Based on record reviews and interviews, the facility failed to maintain coordination between the agencies, individual and the qualified professionals who are responsible for the client's treatment, affecting one of one current client (#1) and one of one former clients (FC #2). The findings are: Finding #1 Review on 11/15/24 of client #1's record revealed: -49 year old male. -Admitted on 10/19/12. -Diagnoses of Moderate Intellectual Developmental Disability and Intermittent Explosive Disorder. Review on 11/25/24 of client #1's treatment plan dated 5/9/24 revealed: "...Long-range Goal 3: [Client #1] effectively communicates with others with no more than 3 VP's (Verbal Prompts)...Where am I now: The Team reviewed this objective and agreed [Client #1] would benefit from supports to learn to effectively express his feelings, [Client #1] currently struggles to express feelings of hurt or pain. [Client #1] would also benefit from supports to develop an understanding of personal space, boundaries when interacting, speaking with others, and respecting other's conversations..." Review on 11/18/24 of a Notebook for client #1 revealed: 8/30/24 - 1st/2nd (shift) "claim he cut his finger on his drawer. out in the community early. 2nd Ok behavior talking like a baby." 8/31/24 - "1st/2nd (shift) no verbal outburst - talking out of his head." 9/7/24 - "Really, acting like he does not know anything but do not want to answer your Questions."	V 291		

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V 291	Continued From page 38 9/14/24 - "completed laundry after several prompts constantly staring - need help with making his bed -oops not me - Trying to sleep all day on 1st shift" 9/21//24 - "trying to nap most of the day- Just Don't Listen [staff #1]" 9/24/24 - [Client #1] wide eyed - constantly staring at staff - every move. thinking its time to eat." 9/27/24 - "up at 6:45 prompts to return to bed prompted at 5:00am to prepare for the Day - he's very determined not to Answer Questions concerns things the he does wrong but threaten to get staff male -[staff #2] when he gets in." 9/28/24 - "[Client #1] out in the community trying to sleep while back to the home." 10/3/24 - "Slow moving today - appt (appointment)" 10/4/24 "slow moving in Activity except eating" 10/10/24 "no behaviors Just seemed like he's out of it" 10/12/24 "Act like he does not know how to house work - folding clothes - know how to eat" 10/15/24 - "..trying to sleep All day - is responding to staff directives." 10/16/24 - "Out in the community talk with [Staff/Client Administrator] -knew her name." 10/18/24 - "out in the community slow paced - but can eat, eat, eat." 10/19/24 - "slow moving - prompts physical assistance shower etc." 10/21/24 - "slow moving - answer some prompts." 10/22/24 - "slow moving - talking a little. [staff #1]" Review on 11/22/24 of client #1's medical records from his primary care provider revealed: -9/30/24- "Reason for Appointment 1. Pt (Patient) routine follow up; med (medication) refill; concerns with weight loss...Review of Systems Medication Check: The patient reports he has a stable mood. He has been losing weight, he lost 6	V 291		

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V 291	Continued From page 39 lbs (pounds) in a month. He has no behaviors. He is doing well on his meds (medications). He has no behaviors per staff. Others present: group home staff, [FS #1]...Vital Signs Wt (Weight): 132 (pounds)." -7/8/24 "...Vital Signs Wt: 138 (pounds)..." Review on 11/18/24 of client #1's medical records from a local hospital revealed: -10/22/24 "ED (Emergency Department) Triage Notes...Pt presents to ED from group home. Reports pt was found with AMS (Altered Mental Status), unsteady gait, weakness and non verbal...Weight: 51.0 kg (kilograms) (114 lb (pounds) 6.7 oz (ounces)...Assessment: [Client #1] is a 49 y.o.(year old) male with PMH (past medical history) of Autism, hypothyroidism, bipolar presenting with AMS. Patient does not have any focal findings on neurological exam. MRI (Magnetic Resonance Imaging) brain ruled out stroke and brain tumors...At this time there are no acute neurological concerns contributing to this patients AMS...Update: Patient is now being treated for catatonia by primary team...Registered Dietitian Note..With the quick turn around with just D5 (Dextrose 5%) fluids supports, suspect severe dehydration and malnutrition at play..." Interview on 11/15/24 client #1's Guardian stated: -When client #1 was admitted to the facility he weighted 149 pounds. -Client #1 lost about "10 pounds each month" since his admission. -Client #1 had been hospitalized since October 22, 2024 and diagnosed with severe malnutrition, dehydration and catatonia. -Client #1's care manager called on 10/22/24 and informed her that he had visited client #1 at the facility and felt client #1 needed to go to the	V 291		

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V 291	Continued From page 40 hospital. -She contacted the Director (Interim Director) on 10/22/24 who spoke with staff #1 and reported client #1 was "fine and nothing was wrong with him." -Staff #1 transported client #1 to a sister facility where she (guardian) had visited him. -When she arrived at the sister facility, client #1 was barely holding himself up at the kitchen bar and looked like he had a "stroke." -Client #1 was leaning on the kitchen bar and his face was drooping and required assistance to walk. -She attempted to get client #1 into her vehicle to transport to the hospital however he was unable to follow her commands to get in the car. -She took client #1 back into the sister facility and called the ambulance. -The facility had not reported any concerns to her. -The facility reported client #1 was doing fine as recent as the day of admission to the hospital. Interview on 11/14/24 client #1's Care Manager stated: -He visited with client #1 at the facility on 10/22/24. -He had concerns client #1 needed to be seen by a doctor that day. -The facility had a scheduled appointment for client #1, but he felt client #1 needed to be seen the same day. -He contacted the Director and client #1's guardian to inform them of concerns. -He noticed on 8/29/24 when he visited client #1 at the facility he had lost weight. -The facility expressed they had bloodwork completed for his weight loss and an appointment with psychiatrist to see if weight loss was related to medications. -Client #1's test results did not reveal weight loss	V 291		

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	MHL026-761	A. BUILDING: _____ B. WING _____	R-C 11/26/2024

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V 291	Continued From page 41 was from a medical issue. Interview on 11/20/24 FC #2 stated: -Client #1 was sick before he went to the hospital. -Client #1 "could not get his words out" and she "could see his ribs when he pulled up his shirt." -Client #1 was sitting on the couch when staff asked him questions he he would just stare. -It was a "week or two" client #1 could not get his words out. -Client #1 did not really eat his food. Interview on 11/18/24 staff #1 stated: -Client #1 always ate "really fast" until his last 2 weeks at the facility he started eating slow. -She noticed on 10/22/24 client #1's hands were "shaking." -When client #1's care manager visited the facility, client #1 tried to stand but the care manager asked him to sit back down. -Client #1 was not talking like he usually talked but he "was talking, its hard to describe." -Client #1 was not talking to his care manager. -She had not recalled if client #1's care manager had requested the facility seek medical attention for client #1. -She continued to monitor client #1. -The Interim Director directed her to take client #1 to the sister facility so she could monitor client #1. Attempted interview on 11/15/24 and 11/18/24 with staff #2 was unsuccessful as calls or text messages were not returned. Attempted interview on 11/18/24 staff #3 disconnected call after introduction and informed of survey. Interview on 11/18/24 staff #4 stated: -Client #1 ate normal at breakfast and always had	V 291		

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V 291	Continued From page 42	V 291		

an appetite.
-"Maybe the last week" before client #1 went to the hospital she noticed weight loss.

Interview on 11/18/24 the Registered Nurse who provided care for client #1 at the hospital stated:
-Client #1 weighted 114.5 lbs at admission on 10/22/24.
-Client #1's weight as of 11/18/24 was 124.02.
-Client was diagnosed with Catatonia described as the state of "not waking, not really responding."

Interview on 11/18/24 the Internal Medicine provider who provided care for client #1 at the hospital stated:
-Client #1 was "malnourished."
-Client was diagnosed with Catatonia described as "complications of psychiatric illness, not interacting, state of isolation, not eating or drinking and not moving."

Finding #2
Review on 11/15/24 of Former Client #2's record revealed:
-45 year old female.
-Unknown admission date.
-Diagnosis of Mild Intellectual Disability.

Interview on 11/20/24 FC #2 stated:
-She was unsure how long she lived at the facility.
-She transferred from a sister facility.

Interview on 11/18/24 FC #2's Department of Social Services legal guardian representative stated:
-She had "issues" with the Interim Director after she informed her FC #2 had to leave the facility.
-FC #2's transition from the facility was "not smooth."

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V 291	Continued From page 43 -She requested FC #2's Social Security Card, Identification, Birth Certificate, Pharmacy and list of medications from the facility. -The facility did not provide her any requested documentation for FC #2 and she had to "start from scratch" with "everything." -She had access to FC #2's "MyChart" and the facility "locked her out of MyChart." -She had not received a discharge summary from the facility. Interview on 11/18/24 staff #1 stated: -FC #2 was discharged on 11/1/24. -She was suppose to transport FC #2 to her medical appointment on 11/1/24 but the Interim Director transported her and she met them at the medical appointment. -The Interim Director was present when FC #2 discharged from the facility. -The Interim Director told her to "leave and not come back." -She had not provided any documentation to FC #2's guardian for discharge. -The Interim Director had all of FC #2's documentation. Interview on 11/18/24 the Staff/Client Administrator stated: -She worked a shift at the facility every Sunday and Thursday from 11pm - 6am during September and October 2024. -Client #1 was typically asleep during her shift. -She had not noticed any changes in client #1's weight. -Client #1 got sick while she was at the facility and gave her a "blank stare." -She did not believe it was "anything alarming" and she knew about his appointment on 11/8/24. -Client #1 was taken to the sister facility because client #1's guardian was to evaluate if he should	V 291		

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V 291	Continued From page 44 be taken to the hospital. -She had not "notice anything" of concern and need for the hospital. -FC #2 was voluntarily discharged. -The Interim Director spoke with the Guardian and Care Manager about FC #2's discharge. -The Interim Director was responsible for the discharge and was present at the facility when FC #2 was discharged. Interview on 11/26/24 Staff/Client Administrator stated: -The client's "notebook" was not supposed to be for review during survey. -The notebook was logs kept between staff and how they communicated between each other. -She had not reviewed client #1's notebook unless a situation occurred and she ask staff about documentation. Interview on 11/15/24 the Interim Director stated: -All staff that worked at the facility was terminated on 11/1/24 due to client #1 being hospitalized and Former Client #2's discharge. -There was "neglect" on the staff's part for the reason client #1 was hospitalized. -The neglect occurred on staff #1's and staff #2's shift as they were responsible for ensuring the client's were fed. -She had visited the facility on Saturday, 10/19/24 to take the clients out to eat. -She observed client #1 asleep on the couch and asked what was wrong with him. -Staff #2 informed her client #1 had been like that for some time and he wanted to observe him further before he called the medics. -Staff #2 described client #1 as "in and out of it all day" stated client #1 was not really communicating with him and was real drowsy for a day or two.	V 291		

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V 291	Continued From page 45 -She contacted the guardian to inform her of what was going on with client #1. -The following day, client #1's Care Manager visited the facility and observed client #1 to be the same state as she observed. -The Care Manager called the client #1's guardian who contacted her and requested the guardian take client #1 to the hospital. -Client #1 had been hospitalized since 10/23/24 and was diagnosed with malnutrition and dehydration. -The Staff/Client Administrator was responsible for FC #2's discharge and discharge summary. Interview on 11/18/24 the Licensee/Qualified Professional stated: -She terminated all the staff at the facility due to client #1 being sick and client #1's guardian "wasn't happy." -Client #1 was in the hospital and she (L/QP) "did not like it." -She interviewed staff #1 to find out when client #1 got sick and "nobody noticed." -Staff #1 said she noticed client #1 was losing weight and she had took client #1 to the doctor. -Client #1 was supposed to return to the doctor in November. Review on 11/26/24 of a Plan of Protection completed by a Contracted QP revealed: -"What immediate action will the facility take to ensure the safety of the consumers in your care? (1.) Upon Entry into The Loving Home's program, the will be an initial comprehensive Evaluation to include weight, Blood pressure, temperature. 2. Vitals will be taken and Recorded on a monthly basis. Documentation will be kept under lock and key. 3. All records will be complete and will be kept in the home office under lock and key. 4. Documentation will be kept on weight gains	V 291		

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V 291	Continued From page 46 and/or losses on a monthly bases. 5. Primary Care Physicians will be contacted if there are any changes in weight losses or gains that are major. -Describe your plans to make sure the above happens. The QP will monitor the provisions of service on a weekly basis. A visit will be conducted in the homes bi-weekly by the QP. All documents will be reviewed and corrected. QP will ensure that All clients will be safe, their individual needs are addressed and met." The facility served clients with diagnoses of Intellectual Disability Disorder and Intermittent Explosive Disorder. FC #2 was discharged from the facility on 11/1/24. The facility had not provided any documentation or items such as identification, birth certificate or a list of medications to the guardian as requested. Client #1 had difficulty when he expressed pain or hurt. The facility documented concerns such as the client #1 sleeping most of the day, not talking as much and slow moving however there was no documented communication between the facility and the legal guardian to express client #1's concerns. The facility staff did not have client #1 evaluated by a doctor to address his concerns of not talking, slow moving and blank stares. Client #1's Care Manager made a visit to the facility on 10/22/24 and expressed concerns of client #1 needed to be evaluated by a doctor. Client #1's last documented medical appointment was on 9/30/24 and it was noted he weight 132 lbs. The facility staff documented and observed changes with client #1 but had not coordinated with providers responsible for his care and treatment about his change in behaviors or sought medical care for client #1. Client #1 was admitted to the hospital on 10/22/24 and weighted 114 lbs, he was treated for malnourishment and diagnosed with Catatonia.	V 291		

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V 291	Continued From page 47 This deficiency constitutes a Type A1 rule violation for serious neglect and must be corrected within 23 days.	V 291		
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		

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V 366	Continued From page 48 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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V 366	Continued From page 49 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 reviews and interviews, the facility failed to implement written policies governing their response to incidents as required. The findings are: Review on 11/18/24 of the facility's incident reports from August - October 2024 revealed: -An undated incomplete Incident and Death Report for client #1.	V 366		

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V 366	Continued From page 50 A request for all facility incident reports was made on 11/15/24, 11/18/24 and 11/26/24. Review on 11/15/24 of client #1's record revealed: -49 year old male. -Admitted on 10/19/12. -Diagnoses of Moderate Intellectual Developmental Disability and Intermittent Explosive Disorder. Review on 11/15/24 of Former Staff (FS) #1's personnel record revealed: -Hire Date: 12/3/11. -Termination date was not provided. -Job Title: Paraprofessional Review on 11/15/24 of FS #2's personnel record revealed: -Hire Date: 12/30/09. -Termination date was not provided. -Job Title: Paraprofessional Interview on 11/19/24 client #1's guardian stated: -She received a call on 11/19/24 from the Interim Director who played a audio (phone) recording for her. -On the audio recording, Former Client (FC) #2 told the Interim Director she saw FS #1 and FS #2 drag client #1 down the hall. FS#1 grabbed client #1's shirt and started hitting him. The Licensee/Qualified Professional (L/QP) told FC #2 "don't you lie" and the camera would have caught it. The L/QP would have FC #2 in front of FS #1 and FS #2 to see if she would repeat allegations. Interview on 11/20/24 FC #2 stated: -Staff #1 took client #1 by his shirt and dragged him on the floor. -It happened several times but could not	V 366		

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V 366	Continued From page 51 remember when. -She told the Interim Director about the incident before she left (11/1/24). Interview on 11/19/24 staff #1 stated: -She was not aware of any allegations made against her. -She had not pushed or dragged client #1. -She had not witness client #1 or Former Client #2 mistreated. Attempted interview on 11/15/24 and 11/18/24 with staff #2 was unsuccessful as calls or text messages were not returned. Interview on 11/18/24 the Staff/Client Administrator stated: -She recalled 3 or 4 incident reports the Interim Director told staff #1 to do. -All incident reports were given to the Interim Director. -She was unsure of who was responsible for reporting to IRIS. Interview on 11/15/24 and 11/18/24 the Interim Director stated: -She was unable to locate any incident reports. -The Staff/Client Administer was responsible for completing the incident reports. -She had emailed the Staff/Client Administrator and requested incident reports. -She believed staff #1 was responsible for client #1's hospitalization. Interview on 11/15/24 and 11/26/24 the L/QP stated: -The Staff/Client Administrator and the Interim Director were responsible for incident reporting. -The policy manual was not available onsite for review.	V 366		

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V 366	Continued From page 52 This deficiency is cross referenced into 10A NCAC 27G .5601 Scope (V289) for a Type B rule violation and must be corrected within 45 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 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:	V 367		

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V 367	Continued From page 53 (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		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL026-761	A. BUILDING: _____ B. WING _____	R-C 11/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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V 367	Continued From page 54 (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 reviews and interviews, the facility failed to ensure an incident report was submitted to the Local Management Entity/Managed Care Organization (LME/MCO) within 72 hours as required. The findings are: Review on 11/15/24 of client #1's record revealed: -49 year old male. -Admitted on 10/19/12. -Diagnoses of Moderate Intellectual Developmental Disability and Intermittent Explosive Disorder. Review on 11/15/24 of Former Staff (FS) #1's personnel record revealed: -Hire Date: 12/3/11. -Termination date was not provided. -Job Title: Paraprofessional Review on 11/15/24 of FS #2's personnel record revealed: -Hire Date: 12/30/09. -Termination date was not provided.	V 367		

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V 367	Continued From page 55 -Job Title: Paraprofessional Review on 11/14/24 of the North Carolina Incident Response Improvement System revealed no incident reports for the facility from September 2024 - Current. Interview on 11/19/24 client #1's guardian stated: -She received a call on 11/19/24 from the Interim Director who played a audio recording for her. -On the audio recording, Former Client (FC) #2 told the Interim Director she saw staff #1 and staff #2 drag client #1 down the hall. Staff #1 grabbed client #1's shirt and started hitting him. The Licensee/Qualified Professional (L/QP) told FC #2 "don't you lie" and the camera would have caught it. The L/QP would have FC #2 in front of staff #1 and Staff #2 to see if she would repeat allegations. Interview on 11/20/24 FC #2 stated: -Staff #1 took client #1 by his shirt and dragged him on the floor. -It happened several times but could not remember when. -She told the Interim Director about the incident before she left (11/1/24). Interview on 11/19/24 staff #1 stated: -She was not aware of any allegations made against her. -She had not pushed or dragged client #1. -She had not witness client #1 or Former Client #2 mistreated. Attempted interview on 11/15/24 and 11/18/24 with staff #2 was unsuccessful as calls or text messages were not returned. Interview on 11/18/24 the Staff/Client	V 367		

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V 367	Continued From page 56 Administrator stated: -She recalled 3 or 4 incident reports the Interim Director told staff #1 to do. -All incident reports were given to the Interim Director. -She was unsure of who was responsible to report to IRIS. Interview on 11/15/24 and 11/18/24 the Interim Director stated: -She was unable to locate any incident reports. -The Staff/Client Administer was responsible to complete the incident reports. -She had emailed the Staff/Client Administrator and requested incident reports. -She believed staff #1 was responsible for client #1's hospitalization. Interview on 11/15/24 the L/QP stated: -The Staff/Client Administrator and the Interim Director were responsible for incident reports. This deficiency is cross referenced into 10A NCAC 27G .5601 Scope (V289) for a Type B rule violation and must be corrected within 45 days.	V 367		
V 500	27D .0101(a-e) Client Rights - Policy on Rights 10A NCAC 27D .0101 POLICY ON RIGHTS RESTRICTIONS AND INTERVENTIONS (a) The governing body shall develop policy that assures the implementation of G.S. 122C-59, G.S. 122C-65, and G.S. 122C-66. (b) The governing body shall develop and implement policy to assure that: (1) all instances of alleged or suspected abuse, neglect or exploitation of clients are reported to the County Department of Social Services as specified in G.S. 108A, Article 6 or	V 500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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V 500	Continued From page 57 G.S. 7A, Article 44; and (2) procedures and safeguards are instituted in accordance with sound medical practice when a medication that is known to present serious risk to the client is prescribed. Particular attention shall be given to the use of neuroleptic medications. (c) In addition to those procedures prohibited in 10A NCAC 27E .0102(1), the governing body of each facility shall develop and implement policy that identifies: (1) any restrictive intervention that is prohibited from use within the facility; and (2) in a 24-hour facility, the circumstances under which staff are prohibited from restricting the rights of a client. (d) If the governing body allows the use of restrictive interventions or if, in a 24-hour facility, the restrictions of client rights specified in G.S. 122C-62(b) and (d) are allowed, the policy shall identify: (1) the permitted restrictive interventions or allowed restrictions; (2) the individual responsible for informing the client; and (3) the due process procedures for an involuntary client who refuses the use of restrictive interventions. (e) If restrictive interventions are allowed for use within the facility, the governing body shall develop and implement policy that assures compliance with Subchapter 27E, Section .0100, which includes: (1) the designation of an individual, who has been trained and who has demonstrated competence to use restrictive interventions, to provide written authorization for the use of restrictive interventions when the original order is renewed for up to a total of 24 hours in	V 500		

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V 500	Continued From page 58 accordance with the time limits specified in 10A NCAC 27E .0104(e)(10)(E); (2) the designation of an individual to be responsible for reviews of the use of restrictive interventions; and (3) the establishment of a process for appeal for the resolution of any disagreement over the planned use of a restrictive intervention. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure all instances of alleged or suspected abuse, neglect or exploitation were reported to the county department of social services (DSS). The findings are: Review on 11/15/24 and 11/26/24 of facility records revealed: -No documentation the allegation of abuse was reported to DSS. Review on 11/15/24 of client #1's record revealed: -49 year old male. -Admitted on 10/19/12. Review on 11/15/24 of Former Staff (FS) #1's personnel record revealed: -Hire Date: 12/3/11. -Termination date was not provided. -Job Title: Direct Care Staff. Review on 11/15/24 of FS #2's personnel record revealed: -Hire Date: 12/30/09. -Termination date was not provided. -Job Title: Direct Care Staff.	V 500		

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V 500	Continued From page 59 Interview on 11/19/24 client #1's guardian stated: -She received a call on 11/19/24 from the Interim Director who played a audio recording for her. -On the audio recording, Former Client (FC) #2 told the Interim Director she saw staff #1 and staff #2 drag client #1 down the hall. Staff #1 grabbed client #1's shirt and started hitting him. The Licensee/Qualified Professional (L/QP) told FC #2 "don't you lie" and the camera would have caught it. The L/QP would have FC #2 in front of staff #1 and Staff #2 to see if she would repeat allegations. Interview on 11/20/24 FC #2 stated: -Staff #1 took client #1 by his shirt and dragged him on the floor. -It happened several times but could not remember when. -She told the Interim Director about the incident before she left (11/1/24). Interview on 11/19/24 staff #1 stated: -She was not aware of any allegations made against her. -She had not pushed or dragged client #1. -She had not witness client #1 or FC #2 mistreated. Attempted interview on 11/15/24 and 11/18/24 with staff #2 was unsuccessful as calls or text messages were not returned. Interview on 11/26/24 the L/QP stated: -The Interim Director informed her of the allegations made against FS #1 and FS #2. -She requested the Interim Director bring FC #2 to see her. -FC #2 alleged she saw FS #1 and FS #2 hit and drag client #1. -She told FC #2 she (FC #2) would need to "say it	V 500		

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V 500	Continued From page 60 to staff" FS #1 and FS #2 of the allegations against them. -FC #2 "lied a lot." -She had not completed an internal investigation or made a report to DSS because she "did not take it serious." This deficiency is cross referenced into 10A NCAC 27G .5601 Scope (V289) for a Type B rule violation and must be corrected within 45 days.	V 500		
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.	V 536		

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V 536	Continued From page 61 (e) Formal refresher training must be completed by each service provider periodically (minimum annually). (f) Content of the training that the service provider wishes to employ must be approved by the Division of MH/DD/SAS pursuant to Paragraph (g) of this Rule. (g) Staff shall demonstrate competence in the following core areas: (1) knowledge and understanding of the people being served; (2) recognizing and interpreting human behavior; (3) recognizing the effect of internal and external stressors that may affect people with disabilities; (4) strategies for building positive relationships with persons with disabilities; (5) recognizing cultural, environmental and organizational factors that may affect people with disabilities; (6) recognizing the importance of and assisting in the person's involvement in making decisions about their life; (7) skills in assessing individual risk for escalating behavior; (8) communication strategies for defusing and de-escalating potentially dangerous behavior; and (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);	V 536		

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V 536	Continued From page 62 (B) when and where they attended; and (C) instructor's name; (2) The Division of MH/DD/SAS may review/request this documentation at any time. (i) Instructor Qualifications and Training Requirements: (1) Trainers shall demonstrate competence by scoring 100% on testing in a training program aimed at preventing, reducing and eliminating the need for restrictive interventions. (2) Trainers shall demonstrate competence by scoring a passing grade on testing in an instructor training program. (3) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (4) The content of the instructor training the service provider plans to employ shall be approved by the Division of MH/DD/SAS pursuant to Subparagraph (i)(5) of this Rule. (5) Acceptable instructor training programs shall include but are not limited to presentation of: (A) understanding the adult learner; (B) methods for teaching content of the course; (C) methods for evaluating trainee 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	V 536		

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V 536	Continued From page 63 annually. (8) Trainers shall complete a refresher instructor training at least every two years. (j) Service providers shall maintain documentation of initial and refresher instructor training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcomes (pass/fail); (B) when and where attended; and (C) instructor's name. (2) The Division of MH/DD/SAS may request and review this documentation any time. (k) Qualifications of Coaches: (1) Coaches shall meet all preparation requirements as a trainer. (2) Coaches shall teach at least three times the course which is being coached. (3) Coaches shall demonstrate competence by completion of coaching or train-the-trainer instruction. (l) Documentation shall be the same preparation as for trainers. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure current training in alternatives to restrictive interventions for one of two audited former staff (FS #1). The findings are: Review on 11/15/24 of FS #1's personnel record	V 536		

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V 536	Continued From page 64 revealed: -Hire Date: 12/3/11. -Termination date was not provided. -No documentation of current training in alternatives to restrictive interventions. Interview on 11/15/24 FS #1 stated: -She worked at the facility for 10-14 years. -Termination date was not provided. -She had received training in Nonviolent Crisis Intervention (NCI). Interview on 11/26/24 the Licensee/Qualified Professional stated: -She had not located the facility's personnel files. -The facility had a complete personnel file for FS #1. -FS #1 was trained in NCI. This deficiency constitutes a re-cited deficiency. This deficiency is cross referenced into 10A NCAC 27G .5601 Scope (V289) for a Type B rule violation and must be corrected within 45 days.	V 536		
V 537	27E .0108 Client Rights - Training in Sec Rest & ITO 10A NCAC 27E .0108 TRAINING IN SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT (a) Seclusion, physical restraint and isolation time-out may be employed only by staff who have been trained and have demonstrated competence in the proper use of and alternatives to these procedures. Facilities shall ensure that staff authorized to employ and terminate these procedures are retrained and have demonstrated competence at least annually.	V 537		

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V 537	Continued From page 65 (b) Prior to providing direct care to people with disabilities whose treatment/habilitation plan includes restrictive interventions, staff including service providers, employees, students or volunteers shall complete training in the use of seclusion, physical restraint and isolation time-out and shall not use these interventions until the training is completed and competence is demonstrated. (c) A pre-requisite for taking this training is demonstrating competence by completion of training in preventing, reducing and eliminating the need for restrictive interventions. (d) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (e) Formal refresher training must be completed by each service provider periodically (minimum annually). (f) Content of the training that the service provider plans to employ must be approved by the Division of MH/DD/SAS pursuant to Paragraph (g) of this Rule. (g) Acceptable training programs shall include, but are not limited to, presentation of: (1) refresher information on alternatives to the use of restrictive interventions; (2) guidelines on when to intervene (understanding imminent danger to self and others); (3) emphasis on safety and respect for the rights and dignity of all persons involved (using concepts of least restrictive interventions and incremental steps in an intervention); (4) strategies for the safe implementation of restrictive interventions;	V 537		

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V 537	Continued From page 66 (5) the use of emergency safety interventions which include continuous assessment and monitoring of the physical and psychological well-being of the client and the safe use of restraint throughout the duration of the restrictive intervention; (6) prohibited procedures; (7) debriefing strategies, including their importance and purpose; and (8) documentation methods/procedures. (h) Service providers shall maintain documentation of initial and refresher training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcomes (pass/fail); (B) when and where they attended; and (C) instructor's name. (2) The Division of MH/DD/SAS may review/request this documentation at any time. (i) Instructor Qualification 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 100% on testing in a training program teaching the use of seclusion, physical restraint and isolation time-out. (3) Trainers shall demonstrate competence by scoring a passing grade on testing in an instructor training program. (4) 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.	V 537		

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V 537	Continued From page 67 (5) 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 (j)(6) of this Rule. (6) Acceptable instructor training programs shall include, but not be limited to, presentation of: (A) understanding the adult learner; (B) methods for teaching content of the course; (C) evaluation of trainee performance; and (D) documentation procedures. (7) Trainers shall be retrained at least annually and demonstrate competence in the use of seclusion, physical restraint and isolation time-out, as specified in Paragraph (a) of this Rule. (8) Trainers shall be currently trained in CPR. (9) Trainers shall have coached experience in teaching the use of restrictive interventions at least two times with a positive review by the coach. (10) Trainers shall teach a program on the use of restrictive interventions at least once annually. (11) Trainers shall complete a refresher instructor training at least every two years. (k) Service providers shall maintain documentation of initial and refresher instructor training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcome (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. (l) Qualifications of Coaches:	V 537		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL026-761	A. BUILDING: _____ B. WING _____	R-C 11/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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V 537	Continued From page 68 (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. (m) 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 one of two audited former staff (FS #1) were trained in restrictive interventions. The findings are: Review on 11/15/24 of FS #1's personnel record revealed: -Hire Date: 12/3/11. -Termination date was not provided. -No documentation of current training in restrictive interventions. Interview on 11/15/24 FS #1 stated: -She worked at the facility for 10-14 years. -She had received training in Nonviolent Crisis Intervention (NCI). Interview on 11/26/24 the Licensee/Qualified Professional stated: -She had not located the facility's personnel files. -The facility had a complete personnel file for FS #1. -FS #1 was trained in NCI.	V 537		

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V 537	Continued From page 69 This deficiency constitutes a re-cited deficiency. This deficiency is cross referenced into 10A NCAC 27G .5601 Scope (V289) for a Type B rule violation and must be corrected within 45 days.	V 537		
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 record review, observations and interviews the facility was not maintained in a safe, clean and attractive manner and free from offensive odors. The findings are: Observation on 11/15/24 at between 11:30 am - 12:30 pm a tour of the facility revealed: -The refrigerator in the kitchen had reddish liquid at the bottom of the refrigerator, gnats on the cheese in the door, a strong foul odor. -The kitchen drawers at the sink were off track or broken. -The half bathroom had paint peeled on the toilet, several broken blind slats and the light above the vanity did not work. -The hallway bathroom had brownish scum in the bathtub, several discolored tiles on the walls above the sink, the window was broken and covered with black tape and the window curtain rod was broken. -Client #1's bedroom light did not work and there was a quarter size hole in the door near the knob. -A vacant client bedroom was used as storage.	V 736		

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V 736	Continued From page 70 Interview on 11/15/24 the Interim Director stated: -The facility was closed. Interview on 11/26/24 the Licensee/Qualified Professional stated: -She was not aware of the maintenance concerns for the facility. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 736		