STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
C R E S T GROUP HOME #3	635 DASHLAND DRIVE FAYETTEVILLE, NC 28303

(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 February 27, 2025. The complaint was substantiated (intake #NC00226519). 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 5 and has a current census of 5. The survey sample consisted of audits of 3 current clients.	V 000		
V 108	27G .0202 (F-I) Personnel Requirements 10A NCAC 27G .0202 PERSONNEL REQUIREMENTS (f) Continuing education shall be documented. (g) Employee training programs shall be provided and, at a minimum, shall consist of the following: (1) general organizational orientation; (2) training on client rights and confidentiality as delineated in 10A NCAC 27C, 27D, 27E, 27F and 10A NCAC 26B; (3) training to meet the mh/dd/sa needs of the client as specified in the treatment/habilitation plan; and (4) training in infectious diseases and bloodborne pathogens. (h) Except as permitted under 10a NCAC 27G .5602(b) of this Subchapter, at least one staff member shall be available in the facility at all times when a client is present. That staff member shall be trained in basic first aid including seizure management, currently trained to provide cardiopulmonary resuscitation and trained in the Heimlich maneuver or other first aid techniques such as those provided by Red Cross,	V 108		

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V 108	Continued From page 1 the American Heart Association or their equivalence for relieving airway obstruction. (i) The governing body shall develop and implement policies and procedures for identifying, reporting, investigating and controlling infectious and communicable diseases of personnel and clients. This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to 1.) ensure 1 of 3 staff (#1) had training to meet the needs of the clients; 2). ensure staff were currently trained in Cardiopulmonary Resuscitation (CPR) and First Aid for 1 of 3 staff. The findings are: Finding #1 Review on 2/25/25 of staff #1's personnel record revealed: -Hire date: 12/3/24. -No evidence of training to meet the needs of the clients. -No evidence of a certification in CPR/First Aid. Interview on 2/25/25 staff #1 stated: -He worked at the facility since December 2024. -He worked alone. -He had not completed CPR/First Aid training since he began working in the facility. Interview on 2/25/25 the Officer Manager stated: -Staff #1 did not complete CPR/First training since he began working at the facility. -The Assistant Director was responsible for scheduling the CPR/First Aid trainings for staff.	V 108		

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V 108	Continued From page 2 Interview on 2/27/25 with the Executive Director/Qualified Professional stated: -Staff worked alone. -The facility recently hired a new staff to assist with keeping record of training for staff. -He was responsible for client specific training. This deficiency has been cited 2 times since the original cite on February 14, 2024 and must be corrected within 30 days.	V 108		
V 112	27G .0205 (C-D) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (c) The plan shall be developed based on the assessment, and in partnership with the client or legally responsible person or both, within 30 days of admission for clients who are expected to receive services beyond 30 days. (d) The plan shall include: (1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement; (2) strategies; (3) staff responsible; (4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both; (5) basis for evaluation or assessment of outcome achievement; and (6) written consent or agreement by the client or responsible party, or a written statement by the provider stating why such consent could not be obtained.	V 112		

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V 112	Continued From page 3	V 112		

This Rule is not met as evidenced by:
Based on record reviews and interviews the facility failed to ensure treatment plans were developed annually for 2 of 3 audited clients (#1,#2).The findings are:

Finding #1
Review on 2/25/25 of client #1's record revealed:
-Date of Admission: 8/2/1991.
-Diagnosis: Severe Intellectual Developmental Disability.
-Treatment plan dated 10/10/23 with no signature.
-No current treatment plan.

Interview on 2/25/25 client #1 stated:
-He did not know what his goals were.
-He had not had a meeting concerning his goals.

Finding #2
Review on 2/25/25 of client #2's record revealed:
-Date of Admission: 3/16/25.
-Diagnoses: Mild Intellectual Disability, Intermittent Explosive Personality, Allergic Rhinitis, Tricuspid Regurgitation and Gastroesophageal Reflux Disease.
-Treatment plan dated 12/22/2020 with no signature.
-No current treatment plan.

Interview on 2/25/25 of client #2 stated:
-She did not know what her goals were.

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V 112	Continued From page 4 -She had not had a meeting concerning her goals. Interview on 2/25/25 staff #1 stated: -He reviewed each client's goals. -He documented towards client's goals. Interview on 2/25/25 staff #3 stated: -She went to one treatment plan meeting. -She was familiar with the client goals. -She documents towards client's goals. -"I believe some goals have expired." Interview on 2/25/25 staff #4 stated: -She was familiar with the client's goals. -She documented towards client's goals. Interview on 2/27/25 the Executive Director/Qualified Professional stated: -He and the Assistant Director were responsible for developing the client treatment plans. -"I hope they did not slip through the cracks and we did not update them." -He would follow up and update the plans. This deficiency has been cited 4 times since the original cite on June 7, 2022 and must be corrected within 30 days.	V 112		
V 114	27G .0207 Emergency Plans and Supplies 10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES (a) Each facility shall develop a written fire plan and a disaster plan and shall make a copy of these plans available to the county emergency services agencies upon request. The plans shall include evacuation	V 114		

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V 114	Continued From page 5 procedures and routes. (b) The plans shall be made available to all staff and evacuation procedures and routes shall be posted in the facility. (c) Fire and disaster drills in a 24-hour facility shall be held at least quarterly and shall be repeated for each shift. Drills shall be conducted under conditions that simulate the facility's response to fire emergencies. (d) Each facility shall have a first aid kit accessible for use. This Rule is not met as evidenced by: Based on record review and interviews the facility failed to ensure fire and disaster drills were held quarterly and repeated on each shift. The findings are: Review on 2/25/25 of the facility's records of fire and disaster drills from October 2024 - December 2024 revealed: -No documentation of a fire or disaster drill for the 4th quarter of 2024 (October-December). Interview on 2/25/25 client #1 stated: -He did not recall the last fire or disaster drill. Interview on 2/25/25 client #2 stated: -She had not participated in a fire or disaster drill latterly. -She was unsure when they last had a fire or disaster drill.	V 114		

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V 114	Continued From page 6 Interview on 2/25/25 staff #1 stated: -He worked at the facility since December 2024. -He had not held or participated in any fire or disaster drills. Interview on 2/26/25 staff #2 stated: -She believed fire and disaster drills were supposed to be held monthly. -She had held fire and disaster drills. Interview on 2/27/25 the Qualified Professional/ Executive Director stated: -There were rotating shifts. -Staff worked Wednesday - Friday, off the weekend and worked Sunday to Wednesday. -Separate staff worked on weekends. -Fire and Disaster drills were completed once a quarter on every shift. -Drills were documented on a form that staff complete and submit to the Assistant Director. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 114		
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,	V 118		

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V 118	Continued From page 7 pharmacist or other legally qualified person and privileged to prepare and administer medications. (4) A Medication Administration Record (MAR) of all drugs administered to each client must be kept current. Medications administered shall be recorded immediately after administration. The MAR is to include the following: (A) client's name; (B) name, strength, and quantity of the drug; (C) instructions for administering the drug; (D) date and time the drug is administered; and (E) name or initials of person administering the drug. (5) Client requests for medication changes or checks shall be recorded and kept with the MAR file followed up by appointment or consultation with a physician. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to administer medications as ordered by the physician and maintain an accurate MAR affecting 2 of 3 audited clients (#1,#2). The findings are: Finding #1 Review on 2/25/25 of client #1's record revealed: -Admitted 8/2/91. -Diagnosis of Severe Intellectual Disability. -No signed physician order for Omega 3 Ethyel Esters 1 gram. (Supplement) Review on 2/25/25 of client #1's signed physician orders revealed:	V 118		

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V 118	Continued From page 8 8/7/24 Quetiapine ER 300 milligram (mg). (Depression) 8/24/24 Olmesartan Hydrochlorothiazide (HCTZ) 20-12.5 mg (Blood Pressure) Omeprazole DR 20 mg (Stomach Acid) 10/4/24 -Ozempic 0.25-0.5 mg once weekly (Type 2 Diabetes) 10/22/24 -Fenofibrate 160 mg daily. (Blood Glucose) 11/27/24 -Dextroamphetamine-Amphetamine 20 mg twice daily. (Attention Deficit Hyperactive Disorder) 2/3/25 -Carbamazepine 200 mg twice daily. (Bipolar) -Magnesium 250 mg daily. (Supplement) 2/12/25 -Lorazepam 1 mg daily. (Seizure) Review on 2/25/25 of client #1's MARs from 12/1/24 - 2/25/25 revealed the following medications were not documented as administered: -Carbamazepine 200 mg in the morning on 12/1/24, 12/14/24-12/16/24, 12/23/24-12/29/24, 1/11/25, 1/12/25, 1/24/25, and in the evening on 12/14/24, 12/15/24, 12/23-12/28/24, 1/11/25, 1/12/25,1/23/25, 1/24/25, 1/29/24, 2/12/25. -Dextroamphetamine-Amphetamine 20 mg on 12/1/24, 12/14/24-12/16/24, 12/23/24-12/29/24, 1/11/25, 1/12/25, 1/24/25, 1/27/25. -Fenofibrate 160 mg, Lorazepam 1 mg, Magnesium 250 mg, Olmesartan HCTZ 20-12.5 mg, Omega 3 Ethyel Esters 1 gram (AM dose), Omeprazole DR 20 mg, Omeprazole DR 20 mg (AM dose) 12/1/24, 12/14/24-12/16/24, 12/23/24-12/29/24, 1/11/25, 1/12/25, 1/24/25 and 1/27/25. -Omega 3 Ethyel Esters 1 gram (PM dose) on	V 118		

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V 118	Continued From page 9 12/12/24-12/15/24, 12/23/24-12/29/24, 1/10/25, 1/11/25, 1/23/24, 1/24/25, 1/29/25, 2/1/25, 2/2/25, 2/12/25. -Quetiapine ER 300 mg (PM dose) on 12/12/24-12/15/24, 12/23/24-12/29/24, 1/10/25, 1/11/25, 1/23/24, 1/24/25, 1/29/25 and 2/12/25. -Ozempic 0.25-0.5 mg on or about 12/26/24 and 1/9/25. Finding #2 Review on 2/25/25 of client #2's record revealed: -Date of Admission: 3/16/15. -Diagnoses: Mild Intellectual Developmental Disability, Intermittent Explosive Personality, Allergic Rhinitis, Tricuspid Regurgitation, Gastroesophageal Reflux Disease. -No documentation of a signed physician order for Quetiapine Extended Release 400 mg. Review on 2/25/25 of client #2's signed physician orders revealed: 3/20/24 Furosemide 20 mg Take one tablet twice daily (Hypertension). 6/21/24 Montelukast Sod 10 mg Take one tablet at bedtime (Allergic Rhinitis). Quetiapine Extended Release (ER) 400 mg tablet every evening (Intermitted Explosive Disorder); Review on 2/25/25 of 12/1/24 - 2/25/25 of client #2's MARs revealed the following medications were not documented as administered: -3/20/24: Furosemide 20 mg; 6 pm dose on 12/1/24, 12/2/24, 12/27/24 and 1/24/25. -6/21/24: Montelukast Sod 10 mg ; 12/27/24, 1/16/24 and 1/24/25. -Quetiapine Extended Release (ER) 400 mg on 12/27/24 and 1/24/25.	V 118		

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V 118	Continued From page 10 Interview on 2/25/25 client #2 stated: -She took medication twice a day. -She did not remember missing any doses of medication. Interview on 2/25/25 staff #1 stated: -He documented a slash on the MAR if the medication had ran out. -He documented on the back of the MAR the reason for a slash. -He did not know why a blank would be on the MARs. Interview on 2/25/25 staff #3 stated: -She documented medication errors on the facility incident report form. -"If there is a blank I would assumed someone forgot to mark it." Interview on 2/25/25 staff #4 stated: -Staff document on the back of the MARs the reason the client did not get the medication. -"If there was a blank I would think the person just didn't sign it." -She would use a slash if the client was on a home visit. Interview on 2/27/25 the Executive Director/Qualified Professional stated: -He visited the facility at least once a month. -He reviewed the MARs when he visited the facility. -There should never be a blank on the MARs. -He did not know what a slash meant on the MARs. This deficiency has been cited 6 times since the original cite on June 7, 2022 and must be corrected within 30 days.	V 118		

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V 120	27G .0209 (E) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (e) Medication Storage: (1) All medication shall be stored: (A) in a securely locked cabinet in a clean, well-lighted, ventilated room between 59 degrees and 86 degrees Fahrenheit; (B) in a refrigerator, if required, between 36 degrees and 46 degrees Fahrenheit. If the refrigerator is used for food items, medications shall be kept in a separate, locked compartment or container; (C) separately for each client; (D) separately for external and internal use; (E) in a secure manner if approved by a physician for a client to self-medicate. (2) Each facility that maintains stocks of controlled substances shall be currently registered under the North Carolina Controlled Substances Act, G.S. 90, Article 5, including any subsequent amendments. This Rule is not met as evidenced by: Based on observation and interviews the facility failed to ensure all medications were kept in a locked compartment or container for 2 of 3 clients audited (#1, #5). The findings are: Review on 2/25/25 of client #1's record revealed: -Admitted 8/2/91. -Diagnosis of Severe Intellectual Disability. Review on 2/25/25 of client #5's record revealed: -Admitted 12/18/08.	V 120		

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V 120	Continued From page 12 -Diagnoses of Seizure Disorder, Depression, Bipolar Disorder and Mild Intellectual Disability. Observation on 2/25/25 at approximately 11:43am of the facility's pantry revealed: -The refrigerator in the pantry contained one box of client #1's Ozempic 0.25-0.5 milligram (mg), one box of client #5's Dupixent 300 mg/2 milliliter syringe and three boxes of client #5's Abilify Maintena 400 mg along with foods such as juice, eggs, cheese, vegetables and condiments. Interview on 2/25/25 client #1 stated: -Staff #1 administered his medications. -He had not seen medications in the refrigerator. Interview on 2/25/25 client #2 stated: -Staff administered her medications. -Medications were kept locked in the staff's office. -She had not seen any medications in the refrigerator. Interview on 2/25/25 staff #1 stated: -Refrigerated medications were unlocked since he was hired. -He understood all medications needed to be locked and secure. Interview on 2/26/25 staff #3 stated: -There is medication in the refrigerator in the pantry. -The pantry door is locked during the day. -Client have access to the pantry when they want a snack. Interview on 2/25/25 staff #4 stated: -The medication in the refrigerator were not locked. -The pantry door is unlocked all day and locked at night.	V 120		

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V 120	Continued From page 13 -Staff use the refrigerator to store personal food and drinks. Interview on 2/27/25 the Qualified Professional stated: -The facility has a lock box that is in the refrigerator. -Staff were instructed to have all medication in refrigerator locked.	V 120		
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 2 of 3 audited staff (#1, #4). The findings are: Finding #1 Review on 2/25/25 of staff #1's personnel record revealed: -Hire Date: 12/3/24. -No documentation HCPR was accessed prior to	V 131		

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V 131	Continued From page 14 hire. Interview on 2/25/25 staff #1 stated: -He had worked at the facility since December 2024. -His job title was Direct Support Professional. Finding #2 Review on 2/25/25 of staff #4's personnel record revealed: -Hire Date: 2/19/24. -No documentation HCPR was accessed prior to hire. Interview on 2/25/25 staff #4 stated: -He had worked at the facility since February 2024. -His job title was Direct Support Professional. Interview on 2/25/25 the Executive Director/Qualified Professional stated: -The HCPR checks should be done prior to hire and annually. -He did not know why staff #1 or staff #4 did not have a HCPR check in their record. This deficiency has been cited 2 times since the original cite on February 14, 2024 and must be corrected within 30 days.	V 131		
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.	V 536		

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V 536	Continued From page 15 (b) Prior to providing services to people with disabilities, staff including service providers, employees, students or volunteers, shall demonstrate competence by successfully completing training in communication skills and other strategies for creating an environment in which the likelihood of imminent danger of abuse or injury to a person with disabilities or others or property damage is prevented. (c) Provider agencies shall establish training based on state competencies, monitor for internal compliance and demonstrate they acted on data gathered. (d) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (e) Formal refresher training must be completed by each service provider periodically (minimum annually). (f) Content of the training that the service 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	V 536		

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V 536	Continued From page 16	V 536		

disabilities;
(6) recognizing the importance of and assisting in the person's involvement in making decisions about their life;
(7) skills in assessing individual risk for escalating behavior;
(8) communication strategies for defusing and de-escalating potentially dangerous behavior; and
(9) positive behavioral supports (providing means for people with disabilities to choose activities which directly oppose or replace behaviors which are unsafe).
(h) Service providers shall maintain documentation of initial and refresher training for at least three years.
(1) Documentation shall include:
(A) who participated in the training and the outcomes (pass/fail);
(B) when and where they attended; and
(C) instructor's name;
(2) The Division of MH/DD/SAS may review/request this documentation at any time.
(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

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service provider plans to employ shall be approved by the Division of MH/DD/SAS pursuant to Subparagraph (i)(5) of this Rule.
(5) Acceptable instructor training programs shall include but are not limited to presentation of:
(A) understanding the adult learner;
(B) methods for teaching content of the course;
(C) methods for evaluating trainee performance; and
(D) documentation procedures.
(6) Trainers shall have coached experience teaching a training program aimed at preventing, reducing and eliminating the need for restrictive interventions at least one time, with positive review by the coach.
(7) Trainers shall teach a training program aimed at preventing, reducing and eliminating the need for restrictive interventions at least once annually.
(8) Trainers shall complete a refresher instructor training at least every two years.
(j) Service providers shall maintain 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

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V 536	Continued From page 18 train-the-trainer instruction. (I) 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 initial training in alternatives to restrictive interventions for 1 of 3 audited staff (#1) and annual training in alternatives to restrictive interventions for 2 of 3 audited staff (#3, #4). The findings are: Finding #1 Review on 2/25/25 of staff #1's personnel record revealed: -Hire Date: 12/3/24. -Job title: Director Support Professional. -No evidence of Non-Violent Crisis Intervention (NCI) Prevention training. Interview on 2/25/2 staff #1 stated: -He had not had alternatives to restrictive intervention training since hired at the facility. Finding #2 Review on 2/25/25 of staff #3's record revealed: -Hire Date: 1/23/24. -Job title: Direct Support Professional. -NCI Prevention training expired on 2/5/25. Interview on 2/26/25 staff #3 stated: -She was trained in NCI after she was hired.	V 536		

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V 536	Continued From page 19 -She had not completed an annual training in NCI. Finding #3 Review on 2/25/25 of staff #4's record revealed: -Date of hire: 2/19/24. -Job title: Direct Support Professional. -NCI training updates in alternatives to restrictive interventions expired 2/18/25. -No current training updates in alternatives to restrictive interventions. Interview on 2/25/25 staff #4 stated: -She had not completed NCI training this year. Interview on 2/25/25 the Office Manager stated: -She did not think staff #3 had an updated NCI training. Interview on 2/27/25 the Executive Director/Qualified Professional stated: -The agency recently hired new staff to keep track of staff trainings. -Some staff have been reported to need updated training.	V 536		