STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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DA-QUEENS HOME	601 EASTERN AVENUE ROCKY MOUNT, NC 27801

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V 000	INITIAL COMMENTS An annual, complaint and follow up survey was completed on 4/17/25. The complaint was substantiated (intake #NC00228427). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disability. This facility is licensed for 6 and has a current census of 5. The survey sample consisted of audits of 3 current clients.	V 000		
V 105	27G .0201 (A) (1-7) Governing Body Policies 10A NCAC 27G .0201 GOVERNING BODY POLICIES (a) The governing body responsible for each facility or service shall develop and implement written policies for the following: (1) delegation of management authority for the operation of the facility and services; (2) criteria for admission; (3) criteria for discharge; (4) admission assessments, including: (A) who will perform the assessment; and (B) time frames for completing assessment. (5) client record management, including: (A) persons authorized to document; (B) transporting records; (C) safeguard of records against loss, tampering, defacement or use by unauthorized persons; (D) assurance of record accessibility to authorized users at all times; and (E) assurance of confidentiality of records. (6) screenings, which shall include: (A) an assessment of the individual's presenting problem or need; (B) an assessment of whether or not the facility	V 105		

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

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V 105	Continued From page 2 This Rule is not met as evidenced by: Based on record review and interview the facility failed to develop and implement adoption of standards that assure operational and programmatic performance meeting applicable standards of practice for the use of a Glucometer instrument including the Clinical Laboratory Improvement Amendments (CLIA) waiver. The findings are: Review on 3/18/25 and 3/19/25 of client #2's record revealed: - Admission date: 1/1/19 - Diagnoses: Mild Intellectual Disorder, Dementia, Dyskinesia, Schizophrenia, Diabetes, Chronic Obstructive Pulmonary Disease - An FL2 dated 12/4/24 for the following: - Blood sugar (BS) checks daily before breakfast Interview on 3/19/25 client #2 reported: - Staff checked his BS daily Review on 3/18/25 and 3/19/25 of client #5's record revealed: - Admission date: 3/11/25 - Diagnoses: Major Depressive Disorder, Intellectual Developmental Disability, Anxiety Disorder, Dementia, Diabetes - Physician's orders dated 3/6/25 for the following: - BS checks daily before meals and at bedtime Interview on 3/19/25 client #5 reported:	V 105		

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V 105	Continued From page 3 - Staff checked his BS daily Inteview on 3/18/25 staff #1 reported: - Clients #2 and #5 had diabetes - She checked their BS daily Interview on 3/18/25 the Owner/Administrator/Qualified Professional reported: - Had attempted to obtain a CLIA waiver - Received the form to complete for the waiver from a staff with the Division of Health Service Regulation (DHSR) on 7/18/24 and returned the form to that staff on 10/14/24 but had not received any further documentation regarding the CLIA waiver - Called and left a voicemail with the DHSR staff that he had returned the waiver to but could not remember when he followed up by phone This deficiency constitutes a recited deficiency. This deficiency is cross referenced into 10A NCAC 27G .0203 Competencies of Qualified Professionals and Associate Professionals (V109) for a Type A1 rule violation and must be corrected within 23 days.	V 105		
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	V 109		

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V 109	Continued From page 4 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 specified in Rule .0104 of this Subchapter. This Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure 1 of 1 Qualified Professional staff (Owner/Administrator/Qualified Professional) demonstrated the knowledge, skills and abilities required by the population served. The findings are:	V 109		

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V 109	Continued From page 5 A. CROSS REFERENCE: 10A NCAC 27G .0201 Governing Body Policies (V105) Based on record review and interview the facility failed to develop and implement adoption of standards that assure operational and programmatic performance meeting applicable standards of practice for the use of a Glucometer instrument including the Clinical Laboratory Improvement Amendments (CLIA) waiver. B. CROSS REFERENCE: 10A NCAC 27G .0205 Assessment and Treatment/Habilitation or Service Plan (V112) Based on record review, observation and interview, the facility failed to develop and implement goals and strategies to meet the needs for 2 of 3 audited clients (#1 and #2). C. CROSS REFERENCE: 10A NCAC 27G .0206 Client Records (V113) Based on record review and interview, the facility failed to maintain complete records affecting 1 of 3 audited clients (#1). D. CROSS REFERENCE: 10A NCAC 27G .0207 Emergency Plans and Supplies (V114) Based on record review and interview the facility failed to ensure fire and disaster drills were completed quarterly and on each shift. E. CROSS REFERENCE: 10A NCAC 27G .0209 Medication Requirements (V123) Based on record reviews and interviews the facility failed to ensure all medication administration errors were immediately reported to a pharmacist or physician affecting 1 of 3 audited clients (#2). F. CROSS REFERENCE: 10A NCAC 27G .5602 Staff (V290) Based on record review and	V 109		

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interview, the facility failed to ensure a client was capable of remaining in the community without supervision affecting 1 of 3 audited clients (#1).

G. CROSS REFERENCE: 10A NCAC 27G .0603 Incident Response Requirements for Category A and B Providers (V366) Based on observation, record reviews and interviews, the facility failed to implement policies governing their response incidents as required.

H. CROSS REFERENCE: 10A NCAC 27G .0604 Incident Reporting Requirements for Category A and B Providers (V367) Based on observation, record reviews and interviews, the facility failed to ensure an incident report was submitted to the Local Management Entity (LME)/Managed Care Organization (MCO) within 72 hours as required.

I. CROSS REFERENCE: 10A NCAC 27F .0102 Living Environment (V539) Based on observation, record review and interview the facility failed to provide accessible areas for personal privacy for 2 of 3 audited clients (#2 and #5).

J. CROSS REFERENCE: 10A NCAC 27G .0303 Location and Exterior Requirements (V736) Based on observation and interview, the facility was not maintained in a safe, clean, attractive and orderly manner.

K. CROSS REFERENCE: 10A NCAC 27G .0304 Facility Design and Equipment (V754) Based on record review, observation, interview and record review the facility failed to maintain a comfort range between 68-80 degrees Fahrenheit.

Review on 3/19/25 of the Owner/Administrator/Qualified Professional's (Owner/Admin/QP) personnel record revealed:

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V 109	Continued From page 7 - Hire date: 11/5/19 - Title: Administrator - Administrator Job Description signed and dated 11/5/19 with the following information: - "Purpose: Assurance of maintenance of all local/state standards and complete management of the home (facility)." - "Assure proper and updated record keeping in all areas." - "Assure proper administration of all medications, medication storage, medication reorders, records, and treatment as ordered by attending physician or relevant to minimum standards." - "Assure proper reporting on all accident/incidents." - "Assure all compliance in sanitation, safety requirements, and building code requirements as required by the Construction Section of Facility Services." - "Assure that duties are performed and properly documented." - "Assure all staff is familiar with and able to apply all the home's accident, fire safety and emergency procedures." Interview on 3/17/25 the Owner/Admin/QP reported: - He was the QP for the facility - "We had another QP when we were licensed but I've been QP since we've been open here" - The former QP began having health problems and the facility was too far for him to travel - "I'm QP, everything falls on me" - He would be recruiting for a new QP for the facility immediately Review on 4/17/25 of the Plan of Protection by the Owner/Admin/QP dated 4/17/25 revealed:	V 109		

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V 109	Continued From page 8 " What immediate action will the facility take to ensure the safety of the consumers in your care? - 1. 10A NCAC 27G .0203 Competencies of Qualified Professionals and Associate Professionals (V109) - Upon hire the new Qualified Professional will provide trainings areas of deficiencies. The QP will ensure tha the Administrator (the Owner/Admin/QP) is trained in all areas of deficiencies. 2. 10A NCAC 27G .0201 Governing Body Policies (V105) - Upon hire, the new QP will provide psychoeducational lesson for the Administrator on CLIA waiver. QP will followed up with DHSR (Division of Health Service Regulation) for CLIA waiver by calling and emailing the authority involved as expected. 3. 10A NCAC 27G .0205 Assessment and Treatment/ Habilitation or Service Plan (V112) - Upon hire, the new QP will review each residents treatment plan to meet their need, the new QP will ensure that each resident has a treatment plan within 30 days of admission 4. 10A NCAC 27G .0206 Client Records (V113) - Upon hire, the new QP will ensure that resident records of event are properly documented. Create additional forms to record episode of residents behavior such as seizure, elopement etc. 5. 10A NCAC 27G .0207 Emergency Plans and Supplies (V114) - Upon hire, the new QP train and provide education on proper ways to conduct fire drills, with admin and facility staff monthly to ensure that fire drills are done within the 3 shifts covered during the work period. 6. 10A NCAC 27G .0209 Medication Requirements (V123) - Upon hire, the new QP will train and monitor staff and administrator on procedures to report when resident medication is missing or not supplied, or missing a dose, or refusing to take the medication.	V 109		

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V 109	Continued From page 9 7. 10A NCAC 27G .5602 Supervised Living for Adults with Mental Illness-Staff (V290) - Upon hire, the new QP will ensure supervised time for resident to matches client's current situation. The new QP will guide and train the facility administrator in implementing unsupervised time for residents according to their current needs. 8. 10A NCAC 27G .0603 Incident Response Requirements for Category A and B Providers (V366) - Upon hire, the new QP will ensure that Administrator implement discussed new strategies with treatment team of the residents to prevent future occurrence by installing monitoring devise and improving the supervision rules of the home. 9. 10A NCAC 27G .0604 Incident Reporting Requirements for Category A and B Providers (V367) - Upon hire, the new QP will ensure that Administrator reports any incident that happened within and outside home on IRIS (Incident Response Improvement System) in timely manner. QP will engage in training and learning how to access and report the incidents by calling the local DSS (Department of Social Services) office. 10. 10A NCAC 27F .0102 Client Rights - Living Environment (V539) - Upon hire, the new QP will ensure that the egress and igress of the home are accessible and maintained. QP will ensure that the resident had privacy by putting the new doors and windows where needed 11. 10A NCAC 27G .0303 Location and Exterior Requirements (V736) - New QP will monitor the Administrator in address safety issues and fire compliance within the home as repair and replaces of equipment is ongoing. 12. 10A NCAC 27G .0304 Facility Design and Equipment (V754) - Type A1 - Upon hire, the new QP will ensure that new heater is installed and repaired with the expected time. Administrator will	V 109		

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V 109	Continued From page 10 contract an electrician to repair, fix or buy a new heater. Describe your plans to make sure the above happens. - Once new QP is hired, Administrator and QP will meet monthly to review and monitor all areas cited in the plan of correction. Administrator will work with QP to make sure that the rules are brought to completion and remain in good standing." This facility served clients with diagnoses that included, but were not limited to, Mild Intellectual Disorder, Dementia, Schizophrenia, Diabetes, Chronic Obstructive Pulmonary Disease, Seizure Disorder, Major Depressive Disorder and Anxiety Disorder. Clients #2 and #5 had Diabetes and both require daily blood sugar checks, which are completed by staff #1. However, the Owner/Admin/QP had not taken the necessary steps to obtain a CLIA waiver for the facility. Client #1 had mobility issues and required daily use of a walker, but consistently refused to use it. Client #1's treatment plan had no goals or strategies to address his use of the walker and the facility did not document or track use or refusal of client #1 to use his walker. Client #1 was receiving services that were not addressed within his treatment plan. Clients #1 and #2 both had behaviors that had prevented them from engaging in day programs, but no strategies or goals were identified in their treatment plans to address those behaviors. Goals for clients #1 and #2 did not match their strengths, preferences or needs. Client #1's record was incomplete, with his listed diagnoses not reflecting his extensive physical disorders, missing hospital and police records, and no documentation or tracking of seizure activity. The Owner/Admin/QP assumed	V 109		

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V 109	Continued From page 11	V 109		

full responsibility of completion of fire and disaster drills at the facility, but he had not completed a fire and disaster drill on each shift and during each quarter. During the month of March 2025, client #2 missed doses of medication for several days while waiting for new orders to be filled, including medications for diabetes and high blood pressure. The Owner/Admin/QP did not immediately report each missed dose of medication to client #2's primary care physician or pharmacist. Client #1 had an unsupervised time assessment that had not been reviewed annually and did not meet his current needs. Client #1 had a seizure disorder with frequent breakthrough seizures, which typically occurred while in the community utilizing unsupervised time. There were at least 8 instances of suspected breakthrough seizure that occurred while client #1 was in the community from 9/22/24-4/10/25, resulting in a response from emergency services. On 9/22/24, client #1 was assaulted while unsupervised in the community. Client #1 sustained facial fractures and injuries which resulted in hospitalization from 9/22/24-10/26/24. The Owner/Admin/QP did not complete an incident report for that assault and hospitalization, and when client #1 returned to the facility, there were no strategies put in place to prevent similar incidents from occuring again. On 3/3/25, client #1 left the facility to utilize unsupervised time and did not return to the facility by curfew. The Owner/Admin/QP called the police at 10:00 pm on 3/3/25 to notify them of client #1's absence, but there was no record of that call being made. Client #1 was found lying in a field on the morning of 3/4/25 and was taken to the hospital, where he was suspected to have had a seizure and it was determined he had hypothermia and was positive for cocaine. It was not known how long client #1 had been lying in the field, but the local overnight

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V 109	Continued From page 12 low temperature for the night of 3/3/25 was 23 degrees Fahrenheit. Client #1 remained in the hospital for 6 days. The Owner/Admin/QP did not complete an incident report for this incident, and there was again no risk/cause analysis or strategies put in place to prevent future events. Despite client #1 not following the guidelines of his outdated unsupervised time, having significant mobility and medical issues, and using illegal substances, he was still allowed to utilize unsupervised time. The bedroom of clients #2 and #5 had one exit doorway that did not have a door which prevented individual privacy. The heating system that heated the downstairs of the facility was not operational, and had not been working since at least 1/9/25. The Owner/Admin/QP had utilized space heaters in the client bedrooms downstairs to keep their bedrooms warm, despite having been informed by DHSR Construction space heaters were a building code violation for this facility. This deficiency constitutes a Type A1 rule violation for serious neglect and must be corrected within 23 days.	V 109		
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	V 112		

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V 112	Continued From page 13 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. This Rule is not met as evidenced by: Based on record review, observation and interview, the facility failed to develop and implement goals and strategies to meet the needs for 2 of 3 audited clients (#1 and #2). The findings are: A. Review on 3/18/25 of client #1's record revealed: - Admission date: 6/12/23 - Diagnoses: Seizure Disorder, Mild Intellectual Disability, Schizoaffective Disorder - Treatment plan dated 6/12/24 revealed: - "Support/Strength: [Client #1] likes to socialize" - "Preferences: [Client #1] wants to live independently" - "Problem/Need: [Client #1] has frequent	V 112		

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seizures at least once a week"
- "Goal 1: [Client #1] will exercise self-control and emotions breakthrough 2 out of 3 times when given situation as evidenced by constant break."
- "Goal 2: [Client #2] will learn to cope with depression by engaging in weekly counseling 2 times a week as evidenced by staff and utilization management."
- No documentation of client outcomes
- No goals or strategies to address client #1's refusal to consistently use his walker or other behavioral concerns
- No basis for evaluation or assessment of outcome achievement

- Registered Nurse evaluation dated 1/9/25 that revealed "Resident (client #1) has walker for ambulation needs. Staff encouraging him to use it."

Attempted review on 3/27/25 of records of client #1's use of or refusal to use his walker was unsuccessful as there was no documentation of this at the facility.

Review on 3/28/25 of records obtained from the local hospital dated from 3/4/25-3/11/25 revealed:
- A physical therapy evaluation dated 3/5/25 that revealed the following:
  - "Problem List: Decreased mobility, impaired balance"
  - "Assessment: Pt (patient) is a 65 year old male admitted to the hospital for fall, hematoma, found outside, + (positive) cocaine on admission...lives in a group home, independent with ambulation and adls (activities of daily living) prior, uses aRW (rolling walker). On eval (evaluation), pt...alert and oriented, strength intact, stuttered speech, bilateral LR (lower extremities) 5/5 (normal rating for muscle

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strength), requires mod (moderate) max (maximum) assist (assistance) for bed mobility, transfers with RW and sidestepping to HOB (head of bed), pt with several episodes of LOB (loss of balance) in sitting and standing with RW, unsafe for further mobility or ambulation at this time, skilled therapy needed to maximize mobility and safety for dc (discharge)."
- An occupational therapy evaluation dated 3/10/25 that revealed the following:
  - "Problem List: Decreased safety awareness, Fall risk, Impaired ADLs"
  - "Assessment: Pt is a 65 yr (year) old male admitted for fall, hematoma, splint on finger...Patient reported he was independent with ADls, IADls (instrumental activities of daily living), and functional mobility with RW. Pt's CLOF (current level of functioning) is SUPV (supervision) for ADLs, SBA (stand-by-assist) for bed mobility, SUPV for sidesteps. Pt would benefit from skills OT (occupational therapy) isntruction to address ADL training, transfers, strength."

Observation on 3/18/25 at 12:52 pm revealed:
- A walker folded and leaned against a wall beside a nightstand in client #1's bedroom

Observation on 3/27/25 at 11:55 am revealed:
- Client #1 leaned slightly to the right when walking and he had a shuffling gait

Interviews on 3/18/25 client #1 reported:
- "I have a standard that I can't maintain with money once a month. A standard with the way I look and dress. I need a job and money"
- "I've had it (walker) for a long time"
- "I use my walker sometimes. I don't want to use it. It makes me tired and I just don't want to use it"

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V 112	Continued From page 16 - "I want to be strong and be independent to do things" Interview on 3/18/25 staff #1 reported: - She had worked at the facility for over a year - Client #1 had a walker but refused to use it - Client #1 was given the walker because of his gait following a hospitalization on 9/22/24 for assault - Prior to the walker, client #1 used a cane - Client #1 was not currently involved in any program during daytime hours Interview on 3/28/25 the Registered Nurse from the facility's pharmacy reported: - She was contracted by the facility's pharmacy - She went to the facility quarterly to observe the clients and check on specific needs, such as mobility - Client #1 had a walker that he should be using daily - She was aware of client #1 refusing to use the walker - The facility staff should encourage client #1 to use the walker daily and document when client #1 is not using the walker Interviews on 3/18/25, 3/19/25 and 4/17/25 the Owner/Administrator/Qualified Professional (Owner/Admin/QP) reported: - He was responsible for completing and updating treatment plans for clients at the facility - Client #1 had a walker but refused to use it - Client #1 had the walker when he moved in to the facility - He was given the walker "because of the way he walks" - "We have a nurse that evaluates them (clients) quarterly" - The facility does not document client #1's use	V 112		

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of or refusal to use his walker
- "One of his (client #1) goals is finding him work"
- He had attempted to coordinate things for client #1 to do during the day
- "VR (Vocational Rehabilitation) comes and takes him (client #1) sometimes, but they have concerns about taking him at times" due to his seizures
- "A family friend takes him to do yard work sometimes"
- Client #1 attended a day program but was discharged due to aggression toward the staff at the day program and refusal to follow the day program rules
- Client #1 had a therapist at one time but they referred him to "another ACTT (Assertive Community Treatment Team)"
- ACTT completed evaluations for client #1 and they called and came to the facility when client #1 was in the hospital but had not returned
- Client #1 was still waiting to get a start date from ACTT
- He had been waiting for someone to follow up from ACTT and had not reached back out to them yet

B. Review on 3/18/25 client #2's record revealed:
- Admission date: 1/1/19
- Diagnoses: Mild Intellectual Disorder, Dementia, Dyskinesia, Schizophrenia, Diabetes, Chronic Obstructive Pulmonary Disease
- Treatment plan dated 1/19/25 revealed:
  - "Support/Strengths: [Client #2] likes to pray"
  - "Preferences: [Client #2] wants to be left alone"
  - "Problem/Need: [Client #2] spread water on equipment"
  - "Goal 1: [Client #2] will learn to exercise

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self-control and emotions breakthrough 2 out of 3 times when given situation as evidenced by disappearance and walking out of the home without disclosing location."
- "Goal 2: [Client #2] will learn to handle anxiety and frustration 2 times daily as evidenced by daily observation by staff and group home report."
- No documentation of client outcomes
- No goals or strategies to address client #2's behavioral concerns
- No basis for evaluation or assessment of outcome achievement

Observation on 3/18/25 at 12:47 pm revealed:
- A clear plastic cover laid over a copy machine in the living room

Observation on 3/19/25 at approximately 2:20 pm revealed:
- Overheard the Owner/Admin/QP ask client #2 "why did you do that?"
- A small puddle of water on the floor and client #2, the Owner/Admin/QP and staff #1 standing together by the puddle
- Staff #1 asked client #2 to go to his bedroom
- The Owner/Admin/QP cleaned up the water from the floor

Interview on 3/19/25 staff #1 reported:
- Client #2 had to be monitored around water because he would pour it out onto the floor or onto items near him
- Client #2 did not leave the facility without staff supervision

Interview on 3/19/25 the Owner/Admin/QP reported:
- Client #2 had been enrolled in a day program but they discharged him because he poured

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V 112	Continued From page 19 water on the day program computers and other office equipment - Client #2 would go to the bathroom and bring back wet napkins or cups of water and pour water on the floor or on items - Client #2 never left the facility without staff supervision or went into the community alone "anymore" This deficiency constitutes a re-cited deficiency. This deficiency is cross referenced into 10A NCAC 27G .0203 Competencies of Qualified Professionals and Associate Professionals (V109) for a Type A1 rule violation and must be corrected within 23 days.	V 112		
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 shall include the name, address and telephone number of the person to be contacted in case of	V 113		

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V 113	Continued From page 20 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 record review and interview, the facility failed to maintain complete records affecting 1 of 3 audited clients (#1). The findings are: Review on 3/18/25 of client #1's record revealed: - Admission date: 6/12/23 - Diagnoses from face sheet: Seizure Disorder, Mild Intellectual Disability, Schizoaffective Disorder - No documentation of progress toward outcomes - No documentation of services provided	V 113		

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Attempted review on 3/27/25 of documentation of client #1's seizure activity in the facility was unsuccessful as no documentation was available.

Attempted review on 3/27/25 of police and hospital records related to an assault on client #1 on 9/22/24 was unsuccessful as no records were at the facility.

Review on 4/7/25 of records obtained from a local hospital regarding client #1's hospitalization from 9/22/24-10/26/24 revealed following information:
- "Chief Complaint: Assault Victim. HPI (History of Present Illness): [Client #1]...presenting to the ED (Emergency Department) via EMS (Emergency Medical Services) after patient (client #1) was reported to be assaulted. EMS was unaware of what the patient was assaulted with or if he lost consciousness. Patient is unable to give history due to possible acuity of assault."
- Client #1's injuries resulted in hospitalization that included 3 transfers between local hospitals from 9/22/24 to 10/26/24 and a transfer to a skilled nursing facility from 10/26/24 to 10/31/24
- Past Medical History: Angina, Assault with orbital le Forte fractures and closed head injury, Congestive Heart Failure, Erectile Dysfunction, Elevated PSA (prostate-specific antigen), Hypertension, Paranoid Schizophrenia, Polysubstance Abuse, Seizures

Review on 3/25/25 of records obtained from a local hospital regarding client #1's hospitalization from 3/4/25-3/11/25 revealed the following information:
- At admission: "HPI: [Client #1]...comes in today for evaluation of being found in a grass field. Reportedly, the patient did not go to his group home last night. He was found sleeping

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outside in the cold. EMS reports his temperature was 93 degrees (Fahrenheit).
- On 3/11/25: "65 year old with schizophrenia, polysubstance abuse, strokes, has been in ER (Emergency Room) for ~6 days (approximately 6 days) because group home manager (Owner/Administrator/Qualified Professional) believes his (client #1) behavior was not at 'baseline' after he originally came into the ER being found on the ground outside in the cold."
- Client #1 remained in the ED of the local hospital from 3/4/25 to 3/11/25
- Past Medical History: Acid Reflux, Chronic nonintractable headache, Erectile Dysfunction, History of Hepatitis C, History of Encephalopathy, Hyperlipidemia, Hypertension, Hypertensive Urgency, Hypokalemia, Liver Disease, Polysubstance Dependence non-opioid in remission, Prostate Cancer, Schizophrenia, Seizures, Stroke, Tobacco Use Disorder

Review on 4/11/25 of a local police incident report dated 9/22/25 obtained from the local police department revealed:
- "On September 22nd, 2024 at 18:33 hours (6:33 pm) a call was received of a physical assault near the [local store] (located at [local address]). Upon my arrival, [local police officer #1] and [local police officer #2] was already on the scene. It was learned from them that the victim, [client #1] ([date of birth]), had injuries from a physical altercation with another male (unknown). It was learned that this event happened because of an argument [client #1] was having with a female (unknown). [Client #1] had visible swelling and was bleeding from his face. He was ultimately taken to [local hospital] because of his injuries by EMS personal. He was unable to answer any questions at that time.
At 21:52 hours (9:52 pm) it was advised by

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Dispatch that [local hospital] had information on [client #1's] condition. It was learned that [client #1] needed to be airlifted to [another local hospital] due to his injuries needing further treatment/surgery (a CT (computed tomography) scan apparently showed fractures to his skull)."

Interview on 3/27/25 staff #1 reported:
- She had worked at the facility for over a year
- The facility did not document seizures for client #1
- Seizures only lasted a second and she would help client #1 to his room and have him lie down
- Most of client #1's seizures occurred while he was in the community

Interviews on 3/18/25 and 3/19/25 the Owner/Administrator/Qualified Professional (Owner/Admin/QP) reported:
- "VR (Vocational Rehabilitation) comes and takes him (client #1) sometimes, but they have concerns about taking him at times" due to his seizures
- Client #1 attended a day program but was discharged due to aggression toward the staff at the day program and refusal to follow the day program rules
- Client #1 had a therapist at one time but they referred him to "another ACTT (Assertive Community Treatment Team)"
- ACTT completed evaluations for client #1 and they called and came to the facility when client #1 was in the hospital but had not returned and he was still waiting to get a start date from ACTT
- He did not have records from any of these services for client #1

Interviews on 3/27/25, 4/15/25 and 4/17/25 the Owner/Admin/QP reported:
- He was responsible for everything in the

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V 113	Continued From page 24 client records - The facility staff documented client #1's seizures if they occurred at the facility but seizures did not typically happen at the facility - He could not locate facility documentation of seizures and was not aware of any pattern to client #1's seizure activity - Client #1's seizures lasted a minute or less and he would lose consciousness and then become lucid after 3 or 4 minutes - He did not have full hospital or medical records for client #1's hospitalizations - He did have the hospital after care summaries for 3/4/25 and other times client #1 had been to the ED for evaluation following a seizure - Full medical records were "hard to get" from the hospital - Regarding client #1's assault on 9/22/25, he had not read the police report and did not know the outcome of the police investigation - When he learned of the assault on client #1, police were already investigating it "so there was no need" for him to speak with them This deficiency is cross referenced into 10A NCAC 27G .0203 Competencies of Qualified Professionals and Associate Professionals (V109) for a Type A1 rule violation and must be corrected within 23 days.	V 113		
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	V 114		

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V 114	Continued From page 25 request. The plans shall include evacuation procedures and routes. (b) The plans shall be made available to all staff and evacuation procedures and routes shall be posted in the facility. (c) Fire and disaster drills in a 24-hour facility shall be held at least quarterly and shall be 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 interview the facility failed to ensure fire and disaster drills were completed quarterly and on each shift. The findings are: Review on 3/18/25 of the facility's fire and disaster drills from July 1, 2024 - March 18, 2025 revealed: - 2 drill forms completed which included: - a simultaneous fire and tornado drill on 2/5/25 at 4:50 pm that revealed a tornado drill that lasted 10 minutes and a fire drill that lasted 5 minutes - a simulataneous fire and tornado drill on 1/3/25 at 11:00 am that revealed a fire drill that lasted 3 minutes and no time specified for a tornado drill Review on 3/20/25 of the facility's fire and	V 114		

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disaster drills from July 1, 2024 - December 31, 2024 revealed:
- No 3rd shift drill for the 3rd quarter of 2024 (July 1 2024 - September 30, 2024)
- No 2nd shift drill for the 4th quarter of 2024 (October 1, 2024 - December 31, 2024)
- Each day a drill was completed, a fire drill and a tornado drill were completed simultaneously and logged on the same form
- Total time for the combined fire and disaster drills varied but were between 3 minutes 8 seconds and 7 minutes 5 seconds

Interview on 3/19/25 client #1 reported:
- The facility practiced fire drills
- He would go into the back yard if there was a fire
- If the fire alarm went off it would sound loud and like "beep beep beep"
- For a tornado drill, he would go under his bed

Interview on 3/19/25 client #2 reported:
- They did not do fire or disaster drills
- He would go outside if there was a fire
- He would go to the basement if there was a tornado

Interview on 3/18/25 staff #1 reported:
- She had worked at the facility over a year
- The Owner/Administrator/Qualified Professional (Owner/Admin/QP) was the only one that completed drills
- The Owner/Admin/QP completed drills monthly

Interview on 3/19/25 the Owner/Admin/QP reported:
- He was responsible for completing drills for the facility
- Had additional drills at his office for 2024

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DA-QUEENS HOME	601 EASTERN AVENUE ROCKY MOUNT, NC 27801

(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 114	Continued From page 27 - Would add them to the fire and disaster drill log at the facility Interview on 3/20/25 the Owner/Admin/QP reported: - The shifts at the facility were 8:00 am - 4:00 pm (first), 4:00 pm - 12:00 am (second) and 12:00 am - 8:00 am (third) - Fire drills and tornado drills were done on the same day and at the same time This deficiency constitutes a re-cited deficiency. This deficiency is cross referenced into 10A NCAC 27G .0203 Competencies of Qualified Professionals and Associate Professionals (V109) for a Type A1 rule violation and must be corrected within 23 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, 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 28 recorded immediately after administration. The MAR is to include the following: (A) client's name; (B) name, strength, and quantity of the drug; (C) instructions for administering the drug; (D) date and time the drug is administered; and (E) name or initials of person administering the drug. (5) Client requests for medication changes or checks shall be recorded and kept with the MAR file followed up by appointment or consultation with a physician. This Rule is not met as evidenced by: Based on record review and interview the facility failed to administer medications on the written order of a physician for 2 of 3 audited clients (#1 and #2) and failed to keep MARs current for 1 of 3 audited clients (#5). The findings are: A. Review on 3/18/25 of client #2's record revealed: - Admission date: 1/1/19 - Diagnoses: Mild Intellectual Disorder, Dementia, Dyskinesia, Schizophrenia, Chronic Obstructive Pulmonary Disease, Diabetes - FL2 dated 12/4/24 with the following information: - Januvia 100 milligrams (mg) take 1 tablet po (by mouth) daily (diabetes) - Polyethylene glycol 3350 mix 17 grams into 8 ounces of water daily (constipation) - Amlodipine besylate 10 mg take 1 tablet po daily (blood pressure)	V 118		

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- Pantoprazole sodium delayed release (DR) 40 mg take 1 tablet po daily (antiacid)
- Fenofibric acid DR 135 mg take 1 capsule po daily (high cholesterol)
- Lisinopril 10 mg take 1 tablet po every day (blood pressure)
- Metformin hydrochloride (HCl) 1000 mg take 1 tablet po twice daily (diabetes)
- Desmopressin acetate 0.1 mg take 1/2 tablet po at bedtime (polyuria)
- Tamsulosin HCl 0.4 mg take 1 capsule po at bedtime (prostate)
- Linzess 145 micrograms (mcg) take 1 capsule po at bedtime (irritable bowel syndrome)
- Atorvastatin 40 mg take 1 tablet po at bedtime (hyperlipidemia)

Reviews on 3/19/25 and 3/27/25 of client #2's March 2025 MAR revealed:
- No staff initials to indicate administration and the letter "B" where staff initials would be for the following medications:
  - Linzess 145 mcg from 3/1/25 - 3/19/25
  - Polyethylene glycol 3350 from 3/10/25 - 3/19/25
  - Januvia 100 mg, amlodipine besylate 10 mg, lisinopril 10 mg and tamsulosin HCl 0.4 mg from 3/15/25 - 3/19/25
  - Metformin HCl 1000 mg from 8 am dose on 3/15/25 - 8 pm dose on 3/19/25
  - Pantoprazole sodium DR 40 mg, fenobric acid DR 135 mg and atorvastatin 40 mg from 3/15/25 - 3/17/25
  - Desmopressin acetate 0.1 mg from 3/15/25 - 3/16/25
- No explanation on the key for the March 2025 MAR to explain what the letter "B" indicated

Interview on 3/27/25 staff #1 reported:
- She administered medication at the facility

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V 118	Continued From page 30	V 118		

daily
- The letter "B" on the March 2025 MAR for client #2 meant that medication was not at the facility and had not been administered
- Medications were normally batched from the facility's pharmacist on the 9th or 10th of every month
- When the medications were batched from the facility's pharmacist in March 2025, several of the medications for client #2 were not sent
- Client #2 received some of the medications on 3/17/25 and some on 3/19/25
- Client #2 had resumed taking all medication by 3/20/25
- Client #2's Linzess was not batched out for March 2025 from the pharmacy with the other medications and she was not sure why

Interview on 3/28/25 the client #2's primary care physician scheduling assistant reported:
- Someone from the facility called on 3/14/25 to request an appointment for client #2
- Client #2 was scheduled for an appointment on 3/17/25

Interview on 3/19/25 at 12:50 pm the facility's pharmacist reported:
- Client #2's medications were batched together and sent out once a month
- The pharmacy received refill orders from client #2's primary care physician on 3/17/25 but only sent out medications that were considered new orders to the facility
- Refill orders were scheduled to be sent to the facility with the batch of medications for the next month
- The pharmacy was not notified by the primary care physician that the facility needed the refill orders immediately
- The refill orders would be sent to the facility

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V 118	Continued From page 31 today, 3/19/25 Interviews on 3/27/25 and 4/17/25 the Owner/Administrator/Qualified Professional (Owner/Admin/QP) reported: - When the medications for client #2 were batched and delivered to the facility on 3/13/25, he realized many of client #2's medications did not have refills - He contacted client #2's primary care physician and got the earliest appointment available on 3/17/25 - Client #2's primary care physician's office was notified on 3/18/25 that the pharmacy had not filled all the orders and the primary care physician reported all medication orders were sent to the pharmacy via fax on 3/17/25 - He spoke with the pharmacy on 3/19/25 and was informed that only the new orders were filled - Refill orders were requested to be filled and delivered on 3/19/25 - He was not sure why client #2 did not have Linzess from 3/1/25-3/19/25 - Client #2 did not like taking polyethylene glycol so they did not obtain it over the counter until the pharmacy refilled it - All of client #2's medications were received and administration resumed by 3/20/25 - He was responsible for reviewing the MARs which included weekly checks to ensure medication administered matched what was on the order and calling pharmacy if any medication was missing B. Review on 3/18/25 and 3/28/25 of client #1's record revealed: - Admission date: 6/12/23 - Diagnoses: Seizure Disorder, Mild Intellectual Disability, Schizoaffective Disorder - Local hospital emergency department	V 118		

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records dated 1/3/25 with the following:
- "Start taking these medications: Lidocaine (Lidoderm) 5% patch - place 1 patch on the skin daily. Apply to affected area for 12 hours only each day (then remove patch), Starting Fri (Friday) 1/3/25, Until Sun (Sunday) 2/2/25, Normal"

- Local hospital emergency department records dated 2/21/25 with the following:
  - "Stop taking these medications: Lidocaine (Lidoderm) 5% patch"

Review on 3/19/25 of client #1's MARs from 1/1/25-3/19/25 revealed:
- No staff initials to indicate application of Lidocaine patch on 1/6/25, 1/8/25, 1/12/25, 1/13/25 and 1/18/25
- Staff initials to indicate application of Lidocaine patch from 2/3/25-3/19/25

Interview on 4/17/25 staff #1 reported:
- Client #1 was no longer wearing the Lidocaine patches
- She stopped administering them in March 2025
- In February 2025 and March 2025, client #1 did not have a Lidocaine patch applied daily and only wore one when he requested it
- She could not provide an answer for why she initialed the Lidocaine patch as applied daily from 2/3/25-3/19/25

Interview on 3/28/25 the Owner/Admin/QP reported:
- Client #1 wore the Lidocaine patch on his waist
- He thought the Lidocaine patch was to be applied as needed and did not realize it was discontinued
- Client #1 had not been wearing the Lidocaine

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patch daily
- He was not sure why the Lidocaine patch was being initialed daily that it was applied

C. Review on 3/18/25 of client #5's record revealed:
- Admission date: 3/11/25
- Diagnoses: Major Depressive Disorder, Intellectual Developmental Disability, Anxiety Disorder, Dementia, Diabetes
- FL2 dated 3/6/25 with the following information:
  - Aripiprazole 5 mg take 1 tablet po every day (mood)
  - Farxiga 10 mg take 1 tablet every day (diabetes)
  - Metformin HCl 1000 mg take 1 tablet po every day with breakfast (diabetes)
  - Multivitamin take 1 tablet po every day (supplement)
  - Methylphenidate 5 mg take 1 tablet po every day (hyperactivity)
  - Vitamin B-12 1000 mcg take 1 tablet po every day (supplement)
  - Sertraline HCl 100 mg take 1 and 1/2 tablet po every day (mood)
  - Cyproheptadine 2 mg/5 milliliters (ml) take 2.5 ml po before meals (appetite)
  - Atorvastatin 40 mg take 1 tablet po at bedtime (high cholesterol)
  - Melatonin 5 mg take 1 tablet at 8 pm (sleep)

Review on 3/19/25 of client #5's MAR from 3/11/25-3/19/25 revealed:
- No staff initials to indicate administration of medication on 3/11/25 and 3/12/25 for aripiprazole, metformin HCl, multivitamin, vitamin B-12, sertraline HCl, cyproheptadine, atorvastatin, melatonin

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V 118	Continued From page 34 - Staff initials to indicate administration of Farxiga and methylphenidate from 3/13/25-3/19/25 Observation on 3/19/25 at 12:50 pm revealed: - Farxiga 10 mg not in the medication cabinet with client #5's other medication - Methylphenidate 5 mg not in the medication cabinet with client #5's other medication Interview on 3/19/25 client #1 reported: - He had just recently moved to the facility - He received his medication as ordered and had been taking all of his medication Interview on 3/19/25 the facility's pharmacist reported: - The pharmacy was not able to fill the order for methylphenidate until client #5 saw his primary care physician due to the medication being a controlled substance - The pharmacy had not filled the order for Farxiga due to the cost of the copay but would fill it with approval from the Owner/Admin/QP Interview on 3/28/25 the Registered Nurse from the facility's pharmacy reported: - She was contracted by the facility's pharmacy - The pharmacy did have a cut-off time and if prescriptions were sent after that time, the medication would not be delivered until the following day - She believed the cut-off time was 2:00 pm - Medications could not be picked up at the pharmacy, but the pharmacy could send the prescriptions to a backup pharmacy if the delayed delivery was an issue Interview on 3/19/25 staff #1 reported: - Methylphenidate and Farxiga were not at the	V 118		

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facility and could not be administered to client #5
- The initials that Farxiga and methylphenidate were administered to client #5 were errors

Interviews on 3/19/25 and 4/10/25 the Owner/Admin/QP reported:
- Client #5 was discharged from a local hospital and admitted to the facility on 3/11/25
- Did not receive client #5's medication from the pharmacy until 3/13/25
- He was not sure why they were not delivered for 2 days
- If an order was sent to the pharmacy after 3:00 pm, the pharmacy will not deliver the medication until the next day
- Medications could not be picked up from the pharmacy and had to be delivered
- Did not request a backup pharmacy for client #5 because he was given some medication at discharge from the hospital
- Client #5 received his medication until the refills were received from the pharmacy but the facility did not begin documenting that medication was administered until the MARs were received from the pharmacy on 3/3/25
- He has requested the pharmacy send the Farxiga so that client can begin taking that
- Client #5 has an appointment scheduled with a primary care physician on 4/2/25 to establish care and he will speak with the doctor about an alternative medication for Farxiga due to the copay and will obtain an order for methylphenidate

Due to the failure to accurately document medication administration, it could not be determined if clients received their medications as ordered by the physician.

This deficiency constitutes a re-cited deficiency

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V 118	Continued From page 36 and must be corrected within 30 days.	V 118		
V 123	27G .0209 (H) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (h) Medication errors. Drug administration errors and significant adverse drug reactions shall be reported immediately to a physician or pharmacist. An entry of the drug administered and the drug reaction shall be properly recorded in the drug record. A client's refusal of a drug shall be charted. . This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to ensure all medication administration errors were immediately reported to a pharmacist or physician affecting 1 of 3 audited clients (#2). The findings are: Review on 3/18/25 of client #2's record revealed: - Admission date: 1/1/19 - Diagnoses: Mild Intellectual Disorder, Dementia, Dyskinesia, Schizophrenia, Chronic Obstructive Pulmonary Disease, Diabetes - FL2 dated 12/4/24 with the following information: - Januvia 100 milligrams (mg) take 1 tablet po (by mouth) daily (diabetes) - Polyethylene glycol 3350 mix 17 grams into 8 ounces of water daily (constipation) - Amlodipine besylate 10 mg take 1 tablet	V 123		

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po daily (blood pressure)
- Pantoprazole sodium delayed release (DR) 40 mg take 1 tablet po daily (antiacid)
- Fenofibric acid DR 135 mg take 1 capsule po daily (high cholesterol)
- Lisinopril 10 mg take 1 tablet po every day (blood pressure)
- Metformin hydrochloride (HCl) 1000 mg take 1 tablet po twice daily (diabetes)
- Desmopressin acetate 0.1 mg take 1/2 tablet po at bedtime (polyuria)
- Tamsulosin hcl 0.4 mg take 1 capsule po at bedtime (prostate)
- Linzess 145 micrograms (mcg) take 1 capsule po at bedtime (irritable bowel syndrome)
- Atorvastatin 40 mg take 1 tablet po at bedtime (hyperlipidemia)

- No documentation the physician or pharmacist had been notified immediately of all medication administration errors in March 2025
- After care summary from client #2's primary care physician dated 3/17/25

Reviews on 3/19/25 and 3/27/25 of client #2's March 2025 MAR revealed:
- No staff initials to to indicate administration and the letter "B" where staff initials would be for the following medications:
  - Linzess 145 mcg from 3/1/25 - 3/19/25
  - Polyethylene glycol 3350 from 3/10/25 - 3/19/25
  - Januvia 100 mg, amlodipine besylate 10 mg, lisinopril 10 mg and tamsulosin HCl 0.4 mg from 3/15/25 - 3/19/25
  - Metformin HCl 1000 mg from 8 am dose on 3/15/25 - 8 pm dose on 3/19/25
  - Pantoprazole sodium DR 40 mg, fenobric acid DR 135 mg and atorvastatin 40 mg from 3/15/25 - 3/17/25
  - Desmopressin acetate 0.1 mg from

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V 123	Continued From page 38 3/15/25 - 3/16/25 - No explanation on the key for the March 2025 MAR to explain what the letter "B" indicated Interview on 3/27/25 staff #1 reported: - The letter "B" on the March 2025 MAR for client #2 indicated that medication was not at the facility and had not been administered - Medications were normally batched from the facility's pharmacist on the 9th or 10th of every month - When the medications were batched from the facility's pharmacist in March 2025, several of the medications for client #2 were not sent - The Owner/Administrator/Qualified Professional (Owner/Admin/QP) was responsible for contacting the doctor or the pharmacist for missed medications - She was not sure when the doctor and pharmacist were notified of the missed medication for client #2 Interviews on 3/27/25 and 4/17/25 the Owner/Admin/QP reported: - He did not notify client #2's primary care physician of all missed doses of medication from 3/1/25 - 3/17/25 until client #2's appointment on 3/17/25 - He went in to the primary care physician's office again on 3/18/25 to notify them that client #2 had not received doses of some of the medication on 3/17/25 and 3/18/25 because some refills were not received from the pharmacy on 3/17/25 - He notified the pharmacy on 3/19/25 that client #2 was still without some medication refills - All of client #2's medications were received and administration resumed by 3/20/25 - He did not notify client #2 primary care physician of any medication that was not	V 123		

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V 123	Continued From page 39 administered on 3/19/25 - He was responsible for reviewing the MARs which included weekly checks to ensure medication administered matched what was on the order, calling the pharmacy if any medication was missing, and notifying client's doctor if any medication was missed This deficiency is cross referenced into 10A NCAC 27G .0203 Competencies of Qualified Professionals and Associate Professionals (V109) for a Type A1 rule violation and must be corrected within 23 days.	V 123		
V 290	27G .5602 Supervised Living - Staff 10A NCAC 27G .5602 STAFF (a) Staff-client ratios above the minimum numbers specified in Paragraphs (b), (c) and (d) of this Rule shall be determined by the facility to enable staff to respond to individualized client needs. (b) A minimum of one staff member shall be present at all times when any adult client is on the premises, except when the client's treatment or habilitation plan documents that the client is capable of remaining in the home or community without supervision. The plan shall be reviewed as needed but not less than annually to ensure the client continues to be capable of remaining in the home or community without supervision for specified periods of time. (c) Staff shall be present in a facility in the following client-staff ratios when more than one child or adolescent client is present: (1) children or adolescents with substance abuse disorders shall be served with a minimum of one staff present for every five or fewer minor clients present. However, only one staff need be	V 290		

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V 290	Continued From page 40 present during sleeping hours if specified by the emergency back-up procedures determined by the governing body; or (2) children or adolescents with developmental disabilities shall be served with one staff present for every one to three clients present and two staff present for every four or more clients present. However, only one staff need be present during sleeping hours if specified by the emergency back-up procedures determined by the governing body. (d) In facilities which serve clients whose primary diagnosis is substance abuse dependency: (1) at least one staff member who is on duty shall be trained in alcohol and other drug withdrawal symptoms and symptoms of secondary complications to alcohol and other drug addiction; and (2) the services of a certified substance abuse counselor shall be available on an as-needed basis for each client. This Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure a client was capable of remaining in the community without supervision affecting 1 of 3 audited clients (#1). The findings are: Review on 3/18/25 of client #1's record revealed: - Admission date: 6/12/23 - Diagnoses: Seizure Disorder, Mild Intellectual Disability, Schizoaffective Disorder - Unsupervised time assessment completed by a former Qualified Professional (QP) of the facility dated 7/1/23 with the following information:	V 290		

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V 290	Continued From page 41 - "Has the individual been determined to be in need of a guardian?" with a checked box to indicate "yes" - "Has a guardian been legally appointed" with a checked box to indicate "yes" - "Guardian's name: None" - "Assessment Scale: (3) Yes...(2) No...If the individual exhibits any of the first 5 issues, independent supervision time should not be approved." - "Does the consumer currently have or have a history of any of the following that could preclude them from having unsupervised time? - "Uncontrolled Seizure Disorder" with a checked box to indicate "2" - "Mobility Issues" with a checked box to indicate "2" - "Non-compliant Behaviors" with a checked box to indicate "2" Reviews on 4/7/25, 4/11/25 and 4/17/25 of documentation and reports related to an incident with client #1 on 9/22/24 revealed: - A local police incident report dated 9/22/24 that revealed the following - "On September 22nd, 2024 at 18:33 hours (6:33 pm) a call was received of a physical assault near the [local store] (located at [local address]). Upon my arrival, [local police officer #1] and [local police officer #2] was already on the scene. It was learned from them that the victim, [client #1] ([date of birth]), had injuries from a physical altercation with another male (unknown). It was learned that this event happened because of an argument [client #1] was having with a female (unknown). [Client #1] had visible swelling and was bleeding from his face. He was ultimately taken to [local hospital] because of his injuries by EMS (emergency medical services) personal. He was unable to	V 290		

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answer any questions at that time.

At 21:52 hours (9:52 pm) it was advised by Dispatch that [local hospital] had information on [client #1's] condition. It was learned that [client #1] needed to be airlifted to [another local hospital] due to his injuries needing further treatment/surgery (a CT (computed tomography) scan apparently showed fractures to his skull)."

- Local hospital medical records from 9/22/25-10/26/25 that revealed the following:
  - "Chief Complaint: Assault Victim. HPI (History of Present Illness): [Client #1]...presenting to the ED (Emergency Department) via EMS after patient (client #1) was reported to be assaulted. EMS was unaware of what the patient was assaulted with or if he lost consciousness. Patient is unable to give history due to possible acuity of assault."
  - On 9/22/24, Urine drug screening revealed client #1 was positive for cocaine and opiates at time of admission
  - On 9/23/24, "Concern for possible orbital compartment syndrome given imaging findings and exam, unable to obtain intraocular pressure given significant edema. Spoke with trauma team and they will reach out to ophthalmology and facial surgery team urgently...patient has a high probability of life-threatening deterioration in conditions..."
  - Client #1 experienced a breakthrough seizure while hospitalized on 10/10/25
  - Client #1's injuries resulted in hospitalization that included 3 transfers between local hospitals from 9/22/24 to 10/26/24 and a transfer to a skilled nursing facility from 10/26/24 to 10/31/24
- EMS records dated 9/22/24 that revealed the following:
  - "64 year old male w/ (with) [local police department]. Patient noted to have been

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assaulted. Officers state patient had been assaulted by calling someone a 'b***h' and hit in the face...Physical assessment revealed traumatic injuries to the face...significant swelling noted in upper left orbit and around the left socket, also some swelling near the left cheek and jawline...high potential for facial fracture, or possible broken nose/jaw..."

- Call received time: 6:37 pm

- A facility sign-out sheet that indicated client #1 signed out of the facility to utilize unsupervised time on 9/22/24 at "3:15"

Reviews on 4/7/25 and 4/17/25 of documentation and reports related to an incident with client #1 on 11/15/24 revealed:

- EMS records dated 11/15/24 that revealed the following:
  - "Upon arrival on scene EMS made entry into business and found an elder age African American man sitting slumped over in a chair being help up by store associates...Store employees claim pt (patient) walked in store stood on aisle and just fell down...Pt then awaken and asked EMS what they were doing, claiming he was fine. EMS explained to pt that we found him unconscious and we have concerns that he may be having a stroke. Pt replied he is not having a stroke and there is nothing wrong with him and he did not want to go to ER...Due to EMS being so concerned about this pt's health, EMS did walk pt to his home (facility) from the business, in case he had another syncope episode."
  - Call received time: 2:15 pm
- A facility sign-out sheet that indicated client #1 signed out of the facility to utilize unsupervised time on 11/15/24 at "12:38"

Reviews on 3/28/25 and 4/7/25 of documentation

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and reports related to an incident with client #1 on 11/28/24 revealed:
- ED records dated 11/28/24 that revealed the following:
  - Client #1 "comes in today after possibly having a seizure in the middle of the street"
  - Client #1 was "not willing to stay" and declined medical intervention and was discharged to the Owner/Administrator/Qualified Professional (Owner/Admin/QP)
  - During his transport back to the facility by the Owner/Admin/QP, client #1 had another seizure and returned to the ED for evaluation
  - Urine drug screening was positive for cannabinoids
  - Client #1 was discharged from the ED and returned to the facility
- EMS records dated 11/28/24 that revealed the following:
  - "EMS personnel arrived on scene with [local fire department]...personnel found on the side of the road with male subject...Patient was confused at initial contact. Patient has a known medical history of seizures. Patient did show evidence of seizures."
  - Call received time: 4:37 pm

Reviews on 3/28/25 and 4/17/25 of documentation and reports related to an incident with client #1 on 12/23/24 revealed:
- ED records dated 12/23/24 that revealed the following:
  - Client #1 "presents to the emergency department via EMS for evaluation following a fall this afternoon. Patient was found at the store following an unwitnessed fall. Patient states that he did lose consciousness. He does not remember what caused him to fall...Per EMS, the patient was initially altered on their arrival."
  - Discharged from ED at 8:31 pm

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V 290	Continued From page 45 - A facility sign-out sheet that indicated client #1 signed out of the facility to utilize unsupervised time on 12/23/24 at "10:07" Reviews on 3/28/25 and 4/7/25 of documentation and reports related to an incident with client #1 on 1/3/25 revealed: - ED records dated 1/3/25 that revealed the following: - Client #1 "presents to emergency department for evaluation of left lateral rib pain status post fall 3 days ago. Patient reports that he had tripped and fell onto his left side hitting his left rib area during the fall...Patient denies hitting his head or any loss of consciousness during the fall." - "Escalation of care including admission/transfer was considered: However, patient was determined to be appropriate for outpatient management." - Client #1 was discharged from the ED and returned to the facility - EMS records dated 1/3/25 that revealed the following: - "Upon arrival patient was found laying in right lateral recumbent position. Caretaker in the household (facility) said patient had fallen 3 days prior to call and started having an increase of pain in left lower abdomen an hour before call and that patient had a history of strokes." - Client #1 was transported to the local hospital for further evaluation - Call received time: 6:46 pm Review on 3/28/25 of reports related to an incident with client #1 on 1/5/25 revealed: - ED records dated 1/5/25 with the following information: - Client #1 "presents to the ED via EMS for evaluation of a seizure. Patient's friend witnessed	V 290		

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a seizure of unknown duration and called EMS."
- Discharged from ED at 5:23 pm

Reviews on 4/7/25 and 4/17/25 of documentation and reports related to an incident with client #1 on 1/14/25 revealed:
- EMS records dated 1/14/25 the revealed the following:
  - "[Local police department] was already on scene. EMS entered the group home through the front door. EMS asked what was going on. [Local police] stated that the located the patient on [nearby street]. [Local police] said that the patient had fallen down and they requested EMS to come to the residence to check the patient out...The patient refused to be evaluated."
- A facility sign-out sheet that indicated client #1 signed out of the facility to utilize unsupervised time on 1/14/25 at "2:42"

Reviews on 3/28/25, 4/7/25 and 4/17/25 of documentation and reports related to an incident with client #1 on 2/21/25 revealed:
- ED records dated 2/21/25 that revealed the following:
  - Client #1 "presents for evaluation after seizure activity. Patient was at a friends house and friends called EMS due to two episodes of seizure like activity. Patient was initially post-octal with EMS, but is now back to baseline."
  - Client #1 was discharged from the ED and returned to the facility
- EMS records dated 2/21/25 that revealed the following:
  - "Upon arrival male patient was found laying in front yard with [local fire department] seizing. [Local fire department] stated that patient was going to a residence to visit someone and fell out in the yard and had multiple seizures. They stated that no one was at the residence but the

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[security camera] notified them that they had activity at their front door and when they viewed the footage they noticed patient lying in the yard seizing."

- Client #1 was transported to the local hospital for further evaluation
- Call received time: 12:01 pm
- A facility sign-out sheet that indicated client #1 signed out of the facility to utilize unsupervised time on 2/21/25 at "10:50"

Reviews on 3/25/25, 4/7/25 and 4/15/25 of of documentation and reports related to an incident with client #1 on 3/4/25 revealed:

- ED records dated 3/4/25 that revealed the following:
  - At admission: "HPI: [Client #1]...comes in today for evaluation of being found in a grass field. Reportedly, the patient did not go to his group home last night. He was found sleeping outside in the cold. EMS reports his temperature was 93 degrees (Fahrenheit).
  - On 3/11/25: "65 year old with schizophrenia, polysubstance abuse, strokes, has been in ER (Emergency Room) for ~6 days (approximately 6 days) because group home manager (Owner/Admin/QP) believes his (client #1) behavior was not at 'baseline' after he originally came into the ER being found on the ground outside in the cold."
  - "Patient likely hypothermic from environmental factors as it was close to freezing temperatures overnight in the area...Possible breakthrough seizure, polysubstance abuse with intoxication, dehydration, among other etiologies"
  - Urine drug screening on 3/4/25 was positive for cocaine
  - Client #1 remained in the ED of the local hospital from 3/4/25 to 3/11/25
- EMS records dated 3/4/25 that revealed the

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V 290	Continued From page 48 following: - "...Arrived on scene of the business to find the patient sitting in a grass field beside the business, with a bystander by his side. Patient was conscious, alert but seemed to have an altered mental status, with a normal work of breathing...Bystander stated that he was riding his bike and was riding past the field when he noticed the patient sitting in the field. He stated that he stopped to check on the patient , and tried to help him to his feet, but the patient was unable to stand...Highest temperature obtained on the patient was 93.7 axillary. Active warming measures were taken on the patient." - Call received time: 7:11 am - Review of local police call logs revealed no call placed from the facility on 3/3/25 or 3/4/25 regarding client #1's absence Reviews on 4/15/25 and 4/17/25 of documentation and reports related to an incident with client #1 on 4/10/25 revealed: - Local police call logs revealed a call placed from the facility on 4/10/25 at 10:47 pm noting that client #1 left the facility at 1:55 pm and had not returned - A facility sign-out sheet that indicated client #1 signed out of the facility to utilize unsupervised time on 4/10/25 at "1:55" Review of local weather recorded from a national weather channel on the night of 3/3/25 revealed a low temperature of 23 degrees Fahrenheit. Observations on 3/18/25: - At 11:27 am, staff #1 and client #1 were standing together and talking and client#1 signed his name to the facility sign-out sheet - At 12:45 pm, client #1 left the facility	V 290		

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V 290	Continued From page 49 Observations on 4/17/25: - At 11:45 am, client #1 opened the side door of the facility and an alarm sounded - At 11:50 am, overheard client #1 notify staff #1 that he was leaving the facility - At 12:17 pm: - Client #1 was walking down the street away from the facility - Staff #1 called to client #1 and told him to return to the facility to organize his bedroom - Client #1 turned around and reentered the facility through the front door - At 12:55, client #1 exited the facility through the side door Interview on 3/18/25 at 11:40 am client #1 reported: - Visited with friends and his ex-girlfriend when he was away from the facility - He was going to the library and did not know how long he would be away from the facility, but he would return - Did not use illegal substances - Went to the hospital last week because he had a seizure Interview on 3/27/25 client #1 reported: - Regarding assault on 9/22/25, he was "beat up" and was in the hospital "for a while" - Could not recall when that happened or how many people assaulted him - He called someone a "b***h" - Still saw them (the person(s) that assaulted him) when he was out of the facility - "I don't mind because I'm ready for combat" - "Hurt my head while I was out then" - "I drink sometimes while I'm out. I drink liquor or beer but not much. Maybe 2 beers a week. Not that hard liquor" - "I smoke marijuana but I don't do it every day.	V 290		

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One day on occasion"
- "I left all those other drugs alone"
- He always signed the facility sign-out form when he left and he never forgot
- "Sometimes I have a seizure when I'm out and people that know me calls the ambulance and then I'll call the house (facility) and let them know I'm in the hospital"

Interview on 4/17/25 client #1 reported:
- He went to the hospital for a seizure last week
- Was in the community when he had the seizure

Interview on 3/18/25 staff #1 reported:
- Had worked at the facility for over a year
- Client #1 had 3 hours of daily unsupervised time in the community
- Clients with unsupervised time were expected to sign out and let her know where they were going prior to leaving the facility
- Client #1 was currently out of the facility utilizing unsupervised time and had told her he was going to the library
- She was "not happy that [client #1] is always having seizures but he is a street guy. He can't stay without going out...He goes out and stresses himself and has a seizure and then goes to the hospital"
- "Don't expect him to come back immediately, but he will be back. He always returns"

Interview on 3/27/25 staff #1 reported:
- Regarding client #1's assault on 9/22/24, "He got beaten up and his eye was messed up. He was in hospital for a long time"
- If client #1 was at the facility, he could go "a long time without seizure...but he walks around and gets stressed" in the community

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V 290	Continued From page 51 - Whenever client #1 was seen at the ED, it was because of a seizure that occurred out of the facility - Client #1 did not consistently use the facility sign-out sheet - She sometimes tried to stop client #1 from leaving the facility by telling him she would call the Owner/Admin/QP - Client #1 left the facility all times of day, sometimes even as late as 8:00 pm - On 3/3/25, client #1 did not sign out - The Owner/Admin/QP had given client #1 his monthly monies around 6:00 pm She could tell by client #1's behavior that he wanted to leave the facility after receiving his monies so she asked client #1 if he was planning to leave and he told her "no" - She went to the kitchen to prepare dinner and when she returned around 6:15 pm or 6:30 pm, client #1 was gone - Client #1 had not returned by approximately 10:00 pm on 3/3/25 so the police were notified - She waited until 10:00 pm to call because it was typical for client #1 to be out that late - Client #1 was hospitalized due to a seizure when he did not return on 3/3/25 - Since he returned from that hospitalization, client #1 had still been leaving the facility but he had been coming back on time - She "did not automatically call the police because you might call and before I can hang up the phone, he's at the door" Interview on 4/17/25 staff #1 reported: - Since she had been working at the facility, client #1 had always spent time alone in the community and his seizures had always been an issue when he was out of the facility - On 4/10/25, she called the police around 10:00 pm because client #1 had not returned to	V 290		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DA-QUEENS HOME	601 EASTERN AVENUE ROCKY MOUNT, NC 27801

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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the facility
- Client #1 had a seizure on 4/10/25 while in the community and went to the ED and then returned to the facility
- Client #1 was not admitted to the hospital on 4/10/25
- Client #1 went to the store alone today

Interviews on 3/18/25, 3/19/25 and 3/27/25 the Owner/Admin/QP reported:
- Client #1 had frequent seizures and went to the hospital via EMS for them
- Last time he went was on 3/4/25 and "they kept him for a few days"
- Client #1 had unsupervised time "but that's because there's nothing we can do to keep [client #1] from leaving" the facility
- Client #1 had seizures while he was in the community on unsupervised time
- On 3/3/25, client #1 left the facility around 3:00 pm or 4:00 pm after he received his monthly monies and did not return to the facility by 10:00 pm so he notified the police
- He did not call the police earlier because "normally he (client #1) comes knocking on the door around 9:00 pm so I wanted to give him some grace to see if he would come back"
- "The police are tired of us calling them because he (client #1) is running late"
- On 3/4/25, the police found client #1 and took him to the hospital
- He was not sure where client #1 was found
- The hospital reported that client #1 was positive for cocaine and had hypothermia
- Client #1 denied using cocaine on 3/3/25 but did report that he used marijuana
- He did not know client #1 was using illegal drugs and the hospital had never notified him of that prior to 3/4/25
- He did not know if client #1 was drinking

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alcohol while he was in the community
- Client #1 took seizure medication as prescribed but was still having breakthrough seizures approximately once per week
- The facility rule was that clients had to return to the facility by 8:00 pm if they were out in the community
- The facility also had a zero tolerance policy for drug and alcohol use
- Client #1 had been consistently coming in past curfew and staying gone past his allotted 3 hours of unsupervised time and had been receiving warnings about that
- "He (client #1) always signs out. He is responsible with that"
- He had noticed a pattern of client #1 returning late each month after he received his monies
- He was responsible for unsupervised time plans for clients at the facility and did not know that unsupervised time plans had to be reviewed and updated at least annually
- "Maybe it (unsupervised time plan) should be updated with all his (client #1) current needs"
- "Thought letting [client #1] know he is not restricted and giving him control and freedom would help him"
- "He (client #1) keeps saying he is going to move out and I told him if he finds a place, I will help him move"

Interviews on 4/15/25 and 4/17/25 the Owner/Admin/QP reported:
- Regarding no police call log for 3/3/25 or 3/4/25, he called the police department, not 911
- He reported to the person that answered the main police number that client #1 had not returned to the facility and they took client #1's information and reported they would look for him
- "911 has given us warnings. We've gotten warnings about trying to do things to keep

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V 290	Continued From page 54 residents (clients) at home (facility) and they got really irritated with us and gave us a warning" - "They said they do something if we call so many times but don't remember what it was" - "We don't call 911 randomly unless there is no other choice" - "They didn't give me a number to call. I just call the main police number" - Following client #1's assault on 9/22/24, client #1 "would still go out so to go out without me having to talk to him every time, we just left the (unsupervised) time in place" - "I've been trying to find a place for him but no one wants to take him. [Client #1] wants to live independently but that can't happen" - "Unsupervised time has always been a problem. It was worse before because he has seizures but its better now" - On 4/10/25, client #1 left the facility and did not return so staff #1 called 911 - Client #1 was at the hospital because he had a seizure while he was in the community, but was not admitted to the hospital - He had been talking to client #1 about staying at the facility but he was still going out - "I think I need to discharge him" This deficieny constitues a re-cited deficiency. This deficiency is cross referenced into 10A NCAC 27G .0203 Competencies of Qualified Professionals and Associate Professionals (V109) for a Type A1 rule violation and must be corrected within 23 days.	V 290		
V 366	27G .0603 Incident Response Requirements 10A NCAC 27G .0603 INCIDENT RESPONSE REQUIREMENTS FOR	V 366		

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V 366	Continued From page 55 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 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;	V 366		

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(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 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:

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V 366	Continued From page 57 (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 observation, record reviews and interviews, the facility failed to implement policies governing their response incidents as required. The findings are: Attempted review on 3/18/25 of the facility's incident reports for period 9/1/24 to 3/18/25 was unsuccessful as no reports were provided. There was no evidence that the facility: - Attended to the health and safety needs of client #1 - Determined the cause of the incidents - Developed and implemented corrective measures - Developed and implemented measures to prevent similar incidents - Assigned a person to be responsible for the implementation of corrections and preventive meausures	V 366		

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V 366	Continued From page 58 - Maintained required documentation Review on 3/18/25 of the Incident Response Improvement System (IRIS) revealed: - No level II or level III incident reports available for review Review on 3/28/25 and 4/7/25 of local hospital medical records for client #1 obtained from local hospitals revealed: - Emergency Department (ED) records dated 9/22/24 that revealed: - "Chief Complaint: Assault Victim. HPI (History of Present Illness): [Client #1]...presenting to the ED via EMS (Emergency Medical Services) after patient (client #1) was reported to be assaulted. EMS was unaware of what the patient was assaulted with or if he lost consciousness. Patient is unable to give history due to possible acuity of assault." - Client #1's injuries resulted in hospitalization that included 3 transfers between local hospitals from 9/22/24 to 10/26/24 and a transfer to a skilled nursing facility from 10/26/24 to 10/31/24 - ED records dated 3/4/25 that revealed: - At admission: "HPI: [Client #1]...comes in today for evaluation of being found in a grass field. Reportedly, the patient did not go to his group home last night. He was found sleeping outside in the cold. EMS reports his temperature was 93 degrees (Fahrenheit)." - On 3/11/25: "65 year old with schizophrenia, polysubstance abuse, strokes, has been in ER (Emergency Room) for ~6 days (approximately 6 days) because group home manager (Owner/Administrator/Qualified Professional) believes his (client #1) behavior was not at 'baseline' after he originally came into the ER being found on the ground outside in the	V 366		

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cold."

- "Patient likely hypothermic from environmental factors as it was close to freezing temperatures overnight in the area...Possible breakthrough seizure, polysubstance abuse with intoxication, dehydration, among other etiologies"
- Client #1 remained in the ED of the local hospital from 3/4/25 to 3/11/25

Review on 4/11/25 of local police incident report dated 9/22/24 obtained from the local police department revealed:

- "On September 22nd, 2024 at 18:33 hours (6:33 pm) a call was received of a physical assault near the [local store] (located at [local address]). Upon my arrival, [local police officer #1] and [local police officer #2] was already on the scene. It was learned from them that the victim, [client #1] ([date of birth]), had injuries from a physical altercation with another male (unknown). It was learned that this event happened because of an argument [client #1] was having with a female (unknown). [Client #1] had visible swelling and was bleeding from his face. He was ultimately taken to [local hospital] because of his injuries by EMS personal. He was unable to answer any questions at that time.

At 21:52 hours (9:52 pm) it was advised by Dispatch that [local hospital] had information on [client #1's] condition. It was learned that [client #1] needed to be airlifted to [another local hospital] due to his injuries needing further treatment/surgery (a CT (computed tomography) scan apparently showed fractures to his skull)."

Review on 4/7/25 of local EMS reports obtained from emergency services revealed:

- EMS records dated 3/4/25 with the following:
  - "...Arrived on scene of the business to find the patient (client #1) sitting in a grass field

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beside the business, with a bystander by his side. Patient was conscious, alert but seemed to have an altered mental status, with a normal work of breathing...Bystander stated that he was riding his bike and was riding past the field when he noticed the patient sitting in the field. He stated that he stopped to check on the patient , and tried to help him to his feet, but the patient was unable to stand...Highest temperature obtained on the patient was 93.7 axillary. Active warming measures were taken on the patient."

- Call received time: 7:11 am

- EMS records dated 9/22/24 with the following:
  - "64 year old male w/ (with) [local police department]. Patient (client #1) noted to have been assaulted. Officers state patient had been assaulted by calling someone a 'b***h' and hit in the face...Physical assessment revealed traumatic injuries to the face...significant swelling noted in upper left orbit and around the left socket, also some swelling near the left cheek and jawline...high potential for facial fracture, or possible broken nose/jaw..."
  - Call received time: 6:37 pm

Observation and interview on 3/27/25 at 11:55 am client #1 reported:
- Did not remember many details about being assaulted on 9/22/24
- Was in the hospital for a long time
- Laughed when asked about being found in the cold on 3/4/25
- His answers regarding both incidents were not clear and difficult to understand

Interview on 3/18/25 and 3/27/25 staff #1 reported:
- Client #1 was in the hospital "last month" for a seizure and "stayed overnight"

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V 366	Continued From page 61 - Several months ago, client #1 "got beaten up and his eye was messed up. He was in hospital for a long time" Interviews on 3/18/25, 3/27/25 and 4/17/25 the Owner/Administrator/Qualified Professional reported: - "Sometime in October," client #1 went to the hospital after he had been "beaten up" in the community - Client #1 "refused to give any details about what happened" during that assault - "He was in the hospital for a while after that" - On 3/3/25, client #1 left and didn't return by 8:00 pm curfew so the facility called the police around 10:00 pm - Police did not indicate where they located client #1 but EMS took him to the hospital - "They (the hospital) kept him for a few days" - He was the QP of the facility and responsible for incident response and follow up - "The strategy is to keep him from going anywhere but what am I supposed to do, tell him he can't go?" This deficiency is cross referenced into 10A NCAC 27G .0203 Competencies of Qualified Professionals and Associate Professionals (V109) for a Type A1 rule violation and must be corrected within 23 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	V 367		

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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:
(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.

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V 367	Continued From page 63 (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; (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.	V 367		

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V 367	Continued From page 64 This Rule is not met as evidenced by: Based on observation, record reviews and interviews, the facility failed to ensure an incident report was submitted to the Local Management Entity (LME)/Managed Care Organization (MCO) within 72 hours as required. The findings are: Attempted review on 3/18/25 of the facility's incident reports for period 9/1/24 to 3/18/25 was unsuccessful as no reports were provided. Review on 3/18/25 of the Incident Response Improvement System (IRIS) revealed: - No level II or level III incident reports available for review Review on 3/28/25 and 4/7/25 of local hospital medical records for client #1 obtained from local hospitals revealed: - Emergency Department (ED) records dated 9/22/24 that revealed: - "Chief Complaint: Assault Victim. HPI (History of Present Illness): [Client #1]...presenting to the ED via EMS (Emergency Medical Services) after patient (client #1) was reported to be assaulted. EMS was unaware of what the patient was assaulted with or if he lost consciousness. Patient is unable to give history due to possible acuity of assault." - Client #1's injuries resulted in hospitalization that included 3 transfers between local hospitals from 9/22/24 to 10/26/24 and a transfer to a skilled nursing facility from 10/26/24 to 10/31/24 - ED records dated 3/4/25 that revealed: - At admission: "HPI: [Client #1]...comes in today for evaluation of being found in a grass	V 367		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 367	Continued From page 65	V 367		

field. Reportedly, the patient did not go to his group home last night. He was found sleeping outside in the cold. EMS reports his temperature was 93 degrees (Fahrenheit)."

- On 3/11/25: "65 year old with schizophrenia, polysubstance abuse, strokes, has been in ER (Emergency Room) for ~6 days (approximately 6 days) because group home manager (Owner/Administrator/Qualified Professional) believes his (client #1) behavior was not at 'baseline' after he originally came into the ER being found on the ground outside in the cold."
- "Patient likely hypothermic from environmental factors as it was close to freezing temperatures overnight in the area...Possible breakthrough seizure, polysubstance abuse with intoxication, dehydration, among other etiologies"
- Client #1 remained in the ED of the local hospital from 3/4/25 to 3/11/25

Review on 4/11/25 of local police incident report dated 9/22/24 obtained from the local police department revealed:

- "On September 22nd, 2024 at 18:33 hours (6:33 pm) a call was received of a physical assault near the [local store] (located at [local address]). Upon my arrival, [local police officer #1] and [local police officer #2] was already on the scene. It was learned from them that the victim, [client #1] ([date of birth]), had injuries from a physical altercation with another male (unknown). It was learned that this event happened because of an argument [client #1] was having with a female (unknown). [Client #1] had visible swelling and was bleeding from his face. He was ultimately taken to [local hospital] because of his injuries by EMS personal. He was unable to answer any questions at that time.

At 21:52 hours (9:52 pm) it was advised by

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V 367	Continued From page 66 Dispatch that [local hospital] had information on [client #1's] condition. It was learned that [client #1] needed to be airlifted to [another local hospital] due to his injuries needing further treatment/surgery (a CT (computed tomography) scan apparently showed fractures to his skull)." Review on 4/7/25 of local EMS reports obtained from emergency services revealed: - EMS records dated 3/4/25 with the following: - "...Arrived on scene of the business to find the patient (client #1) sitting in a grass field beside the business, with a bystander by his side. Patient was conscious, alert but seemed to have an altered mental status, with a normal work of breathing...Bystander stated that he was riding his bike and was riding past the field when he noticed the patient sitting in the field. He stated that he stopped to check on the patient , and tried to help him to his feet, but the patient was unable to stand...Highest temperature obtained on the patient was 93.7 axillary. Active warming measures were taken on the patient." - Call received time: 7:11 am - EMS records dated 9/22/24 with the following: - "64 year old male w/ (with) [local police department]. Patient (client #1) noted to have been assaulted. Officers state patient had been assaulted by calling someone a 'b***h' and hit in the face...Physical assessment revealed traumatic injuries to the face...significant swelling noted in upper left orbit and around the left socket, also some swelling near the left cheek and jawline...high potential for facial fracture, or possible broken nose/jaw..." - Call received time: 6:37 pm Observation and interview on 3/27/25 at 11:55 am client #1 reported:	V 367		

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V 367	Continued From page 67 - He did not remember many details about being assaulted on 9/22/25 - He was in the hospital for a long time - Laughed when asked about being found in the cold on 3/4/25 - His answers regarding both incidents were not clear and difficult to understand Interview on 3/18/25 and 3/27/25 staff #1 reported: - Client #1 was in the hospital "last month" for a seizure and "stayed overnight" - Several months ago, client #1 "got beaten up and his eye was messed up. He was in hospital for a long time" Interviews on 3/18/25, 3/27/25 and 4/15/25 the Owner/Administrator/Qualified Professional reported: - "Sometime in October", client #1 went to hospital after he had been "beaten up" in the community - Client #1 "refused to give any details about what happened" during that assault - "He was in the hospital for a while after that" - On 3/3/25, client #1 left and didn't return by 8:00 pm curfew so the facility called the police around 10:00 pm - Police did not indicate where they located client #1 but EMS took him to the hospital - "They (the hospital) kept him for a few days" - He was the QP and responsible for completing incident reports - He did not complete an IRIS for either incident - Internal incident reports were completed but had forgotten to submit an IRIS report This deficiency constitutes a re-cited deficiency.	V 367		

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V 367	Continued From page 68 This deficiency is cross referenced into 10A NCAC 27G .0203 Competencies of Qualified Professionals and Associate Professionals (V109) for a Type A1 rule violation and must be corrected within 23 days.	V 367		
V 539	27F .0102 Client Rights - Living Environment 10A NCAC 27F .0102 LIVING ENVIRONMENT (a) Each client shall be provided: (1) an atmosphere conducive to uninterrupted sleep during scheduled sleeping hours, consistent with the types of services being provided and the type of clients being served; and (2) accessible areas for personal privacy, for at least limited periods of time, unless determined inappropriate by the treatment or habilitation team. (b) Each client shall be free to suitably decorate his room, or his portion of a multi-resident room, with respect to choice, normalization principles, and with respect for the physical structure. Any restrictions on this freedom shall be carried out in accordance with governing body policy. This Rule is not met as evidenced by: Based on observation and interview the facility failed to provide accessible areas for personal privacy for 2 of 3 audited clients (#2 and #5). The findings are: Observation on 3/18/25 at 12:47 pm of the bedroom of clients #2 and #5 revealed a doorway with no door that opened to a jack and jill hallway that connected to the bedroom of clients #1 and	V 539		

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V 539	Continued From page 69 #3. Interview on 3/27/25 client #1 reported: - He exited his bedroom through the bedroom of clients #2 and #5 Interview on 3/19/25 client #2 reported: - He had a doorway in his bedroom that did not have a door - Having no door was "fine" Interview on 3/19/25 client #5 reported: - He had just recently moved into the facility - He shared a room with client #2 - The doorway without a door did not bother him Interview on 4/15/25 the Owner/Administrator/Qualified Professional reported: - The doorway in the bedroom of clients #2 and #5 had never had a door - "I have not thought about putting a door up there" - "That's how I got the house (facility) and I'm not sure what the purpose of putting a door there would be" - Clients #1 and #3 were able to close the door to their bedroom which gave clients #2 and #5 privacy - The open doorway in the bedroom of clients #2 and #5 "only" opened into the hallway - He had never before considered the issue of privacy for clients #2 and #5 due to the lack of a door This deficiency is cross referenced into 10A NCAC 27G .0203 Competencies of Qualified Professionals and Associate Professionals (V109) for a Type A1 rule violation and must be	V 539		

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V 539	Continued From page 70 corrected within 23 days.	V 539		
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, observation and interview, the facility was not maintained in a safe, clean, attractive and orderly manner. The findings are: Review of Division of Health Services Regulation (DHSR) Construction report dated 3/12/25 revealed: - "At the time of the survey it was observed that there was an extension cord in bedroom #2 which is a potential fire hazard. This is not compliant with the rule. Take the necessary steps to remove any extension cords and replace them with a protected surge strip." Observation on 3/18/25 at 12:47 pm revealed: - The dining room had the following: - A blind with 1 broken slat - A large, red coiled space heater on the floor that was not plugged in - 4 outdoor plastic chairs and a stationary office chair around the dining room table - Overhead light fixture with 3 out of 5 light bulbs not working - The vent cover at the bottom of the refrigerator was missing - The kitchen had the following:	V 736		

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V 736	Continued From page 71 - A single high-pitched chirp every 60 seconds which originated from a smoke detector in the kitchen - A double door hanging kitchen cabinet was no longer secured to the wall and had 1 door that was only attached at the upper hinge and 1 only attached at the lower hinge - Approximately 12 inches by 8 inches of the popcorn kitchen ceiling was peeling off and hanging - Bedroom of clients #2 and #5 had the following: - A blind with 6 broken slats - A small space heater on the floor that was plugged directly into the wall and turned on - A dresser turned backwards with the drawers facing the wall - 1 electrical extension cord plugged into the wall with a television plugged into it - An outdoor plastic chair by the window - Bedroom for clients #1 and #3 had the following: - A small space heater on the floor that was plugged directly into the wall and turned on - 1 electrical extension cord stretched across the floor the entire width of the room - Bedroom for client #4 had the following: - Ceiling fan and ceiling fan light that did not work - A lamp on the floor with no lampshade and the socket and bulb hanging from the cord - Downstairs bathroom with the following: - Tank cover on the back of the toilet had a crack from the back edge to the lower right corner - The double door hanging bathroom cabinet had 1 door that was only attached at the bottom hinge - Upstairs bathroom with the following: - 4 12 inch by 12 inch mosaic tile sheets were missing from the wall	V 736		

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V 736	Continued From page 72 - 2 12 inch by 12 inch mosaic tile sheet were loose at the corner and were hanging from the wall - A black substance speckled across the entire ceiling Interviews on 3/28/25 and 4/17/25 DHSR Construction surveyor reported: - She was at the facility on 3/12/25 - The facility was using a space heater in the dining room at that time - She did not see space heaters in the bedrooms on 3/12/25 - The Owner/Administrator/Qualified Professional (Owner/Admin/QP) was only at the facility for about 5 minutes while she was there - She told staff #1 that space heaters were against building code and they should not be used - Space heaters were against building code due to being a fire hazard - "The ones where the coil gets red, the coil can overheat and start a fire" - "The small ones especially can get tipped over and cause a fire" Interview on 3/18/25 staff #1 reported: - She had worked at the facility for over a year - If she noticed something that needed repair, she notified the Owner/Admin/QP - She was at the facility when DHSR Construction came on 3/12/25 - She and the Owner/Admin/QP discussed the issues in the DHSR construction survey - The space heaters were being used because the heat was not working - They have a handyman that does repairs for the facility Interviews on 3/18/25, 3/25/25 and 4/10/25 the	V 736		

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V 736	Continued From page 73 Owner/Admin/QP reported: - He owned the facility and was responsible for all repairs and maintenance - He had 2 handymen that assisted with repairs at the facility - On 3/18/25, he was just hearing the smoke detector in the kitchen for the first time and would change the batteries - The dresser in the bedroom of clients #2 and #5 was turned backwards because client #2 often rearranges the furniture - He had an appointment with one of the handymen on 3/20/25 to make some repairs - He knew he would be fixing the cabinet in the kitchen, the ceiling fan and light in client #4's bedroom, and the tile in the bathroom upstairs - He bought the space heaters for the client bedrooms when the heat stopped working - He knew the facility was not supposed to be using space heaters - DHSR Construction surveyor had told them that the space heaters were against building code This deficieny constitues a re-cited deficiency. This deficiency is cross referenced into 10A NCAC 27G .0203 Competencies of Qualified Professionals and Associate Professionals (V109) for a Type A1 rule violation and must be corrected within 23 days.	V 736		
V 746	27G .0304(b)(1) Unobstructed Doors, Stairs, Corridors 10A NCAC 27G .0304 FACILITY DESIGN AND EQUIPMENT (b) Safety: Each facility shall be designed, constructed and equipped in a manner that ensures the physical safety of clients, staff and	V 746		

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V 746	Continued From page 74 visitors. (1) All hallways, doorways, entrances, ramps, steps and corridors shall be kept clear and unobstructed at all times. This Rule is not met as evidenced by: Based on record review, observation and interview, the facility failed to keep hallways and doorways clear and unobstructed at all times. The findings are: Review of Division of Health Services Regulation (DHSR) Construction report dated 3/12/25 revealed: - "At the time of the survey it was observed that the hallway adjacent to bedroom #2 entry door was blocked with stored items. This is a pathway in the event of a fire or other emergencies. This is not compliant with the rule. Take the necessary steps to remove the stored items and always maintain a path not less than 36 inches." Observation on 3/18/25 at 12:47 pm revealed: - A doorway from the bedroom of clients #1 and #3 that lead into the hallway between the kitchen and the living room - A second doorway from the bedroom of clients #1 and #3 that lead into the bedroom of clients #2 and #5 - The hallway that lead from the kitchen to the living room was lined with items including: - One 18 gallon plastic storage container with no lid filled with clothing items that were stacked approximately 12 inches beyond the top of the container and was placed in front of half the doorway that lead to the bedroom of clients #1 and #3 - One 18 gallon plastic storage container	V 746		

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V 746	Continued From page 75	V 746		

with the lid attached and a 15 inch by 12 inch cardboard file box and a standard sized bed pillow placed on top
- One 27 gallon plastic storage container with the lid attached topped with a round laundry basket with unknown objects that were covered by a blanket
- One 19.8 inch by 13.8 inch attached lid storage container topped with a plastic reusable shopping bag of unknown contents
- One round laundry basket filled with clothing items

Observation on 3/27/25 at 10:19 am revealed:
- The hallway that lead from the kitchen to the living room had been cleared of all items
- The doorway that lead from the hallway to the bedroom of clients #1 and #3 was clear and unobstructed

Interview on 3/27/25 client #1 reported:
- He didn't know how long his doorway had been blocked
- He went out of his bedroom through the bedroom of clients #2 and #5

Interview on 3/27/25 staff #1 reported:
- Client #1 would often have episodes of nighttime bed wetting
- Client #1 would wake following an episode of nighttime bed wetting and remove his clothes and place them in the dresser with clean clothing
- She put client #1's clothing in the hallway outside his bedroom so that he could place dirty clothes there and get clean clothes from the dresser
- Client #1 would also wake during the night and go into the kitchen eat

Interviews on 3/18/25 and 3/27/25 the

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V 746	Continued From page 76 Owner/Administrator/Qualified Professional (Owner/Admin/QP) reported: - The door leading to the hallway from the bedroom of clients #1 and #3 was blocked because client #1 "goes out during the night and goes into the kitchen and eats everything" - He had the hallway cleared on 3/24/25 Review on 3/27/25 of the Plan of Protection by the Owner/Admin/QP dated 3/27/25 revealed: " What immediate action will the facility take to ensure the safety of the consumers in your care? - On 3/24/25, The egress door has been opened and is accessible. Resident (client #1) was spoken to desist from such behavior. The hallway will remain unobstructed and accessible. Describe your plans to make sure the above happens. - Resident was using the door to go to the kitchen at night and steal items." This facility served clients with diagnoses that included, but were not limited to, Mild Intellectual Disorder, Dementia, Schizophrenia, Diabetes, Chronic Obstructive Pulmonary Disease, Seizure Disorder, Major Depressive Disorder and Anxiety Disorder. Clients #1 and #3 had a bedroom door that opened in the hallway that lead to the kitchen and the living room, as well as a bedroom door that lead into the bedroom of clients #2 and #5. That doorway that lead into the hallway was partially obstructed by items that were lined against the wall in the hallway, resulting in clients #1 and #3 having to exit their bedroom through the bedroom of clients #2 and #5 and not having direct egress to a common area. The hallway was also partially obstructed due to items being lined along the wall creating a design that did not ensure the physical safety of the clients. Based	V 746		

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V 746	Continued From page 77 on the lack of egress, this deficiency constitutes a Type A2 rule violation for substantial risk of serious harm and must be corrected within 23 days.	V 746		
V 754	27G .0304(c) Comfort Zone 10A NCAC 27G .0304 FACILITY DESIGN AND EQUIPMENT (c) Comfort Zone: Each 24-hour facility shall provide heating and air-cooling equipment to maintain a comfort range between 68 and 80 degrees Fahrenheit. (1) This requirement shall not apply to therapeutic (habilitative) camps and other 24-hour facilities for six or fewer clients. (2) Facilities licensed prior to October 1, 1988 shall not be required to add or install cooling equipment if not already installed. This Rule is not met as evidenced by: Based on record review, observation, interview and record review the facility failed to maintain a comfort range between 68-80 degrees Fahrenheit. The findings are: Observation at 3/18/25 at 11:27 am revealed: - Client #1 wearing a knit hat, a fleece jacket and a coat inside the facility Observation on 3/18/25 at 12:54 pm revealed: - Facility thermostat in the downstairs hallway was set to 75 degrees Fahrenheit - Facility thermostat in the downstairs hallway was reading a temperature of 65 degrees Fahrenheit - A telephone conversation between the	V 754		

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V 754	Continued From page 78 Owner/Administrator/Qualified Professional (Owner/Admin/QP) and a handyman used for repairs at the facility in which the handyman reported he would be at the facility on 3/20/25 or 3/21/25 to repair the heating system - Space heaters in the bedrooms of clients #1, #2, #3 and #5 that were plugged in and on - A space heater in the dining room that was not plugged in Review of Division of Health Services Regulation (DHSR) Construction report dated 3/12/25 revealed: - "At the time of the survey it was observed that the temperature within the home was 65 degrees Fahrenheit with the thermostat set at 75 degrees Fahrenheit. After speaking with the staff person present, it was identified that the heat was not working. This is not compliant with the rule. Take the necessary steps to repair or replace the heating system." Review on 3/31/25 of invoices for heating system repairs revealed: - Invoice dated 9/11/24 with the following information: - "20 amp (ampere) home line broken replace a 20 amp breaker fined the essue with overload had to split the load" - No additional invoices were available for review Interview on 3/18/25 client #1 reported: - He did not know anything about the heat - He was wearing layers of clothing because it was cold outside - It was not cold in his room or in the facility Interview on 3/19/25 client #2 reported: - The heat was broken but he did not know	V 754		

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	MHL033-141	A. BUILDING: _____ B. WING _____	R 04/17/2025

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V 754	Continued From page 79	V 754		

how long
- He had not been cold in the facility

Interview on 3/19/25 client #5 reported:
- He moved in to the facility last week
- The heat in the facility was not working but it had not bothered him

Interview on 4/8/25 client #1's sister reported:
- She visited with client #1 at the facility approximately every 2 weeks
- She was not aware that the heat at the facility was not currently working
- She was aware that the heat was not working in January or February of 2025 and the Owner/Admin/QP reported it had just stopped working and it was getting fixed
- She was at the facility during the holidays of 2024 and it was working at that time
- She was concerned that there was no heat at the facility and would be checking on that

Interview on 3/18/25 staff #1 reported:
- The heat had not been working "for a couple of weeks"
- The heating issue started with the air conditioning not working and someone came and repaired that issue
- Last week, someone came to look at the heating system and he was coming back this week
- Clients had "not been impacted by it" and their rooms were warm because they were using space heaters

Interview on 3/28/25 the Registered Nurse from the facility's pharmacy reported:
- She was contracted by the facility's pharmacy
- She went to the facility quarterly to observe the clients and check on specific needs, such as

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V 754	Continued From page 80	V 754		

mobility
- She was at the facility on 1/9/25 and the heat was not working at that time
- She contacted the Owner/Admin/QP and "kind of made a big deal about it because there was inclement weather coming in that night and told him if someone couldn't get out there to fix it, he needed to move the residents somewhere else"
- She noted that the downstairs felt cold and a space heater was being used in the dining room but she was not sure about the client bedrooms

Interview on 4/8/25 the facility's heating repairman reported:
- He completed electrical and heating system repairs at the facility
- He had not been to the facility recently
- He recalled replacing a breaker at the facility but did not recall when
- Last time he was at the facility, he informed the Owner/Admin/QP that the heat exchanger was no longer good in the heating system
- The Owner/Admin/QP asked him to repair it but he informed the Owner/Admin/QP that the system could not be repaired and would have to be replaced
- He did not recall being at the facility in 2025 but could not confirm
- He provided invoices to the Owner/Admin/QP each time he completed work at the facility

Interview on 3/18/25 the Owner/Admin/QP reported:
- The thermostat in the hallway that read 65 degrees Fahrenheit was the thermostat that controlled the temperature for the downstairs of the facility
- The heating system initially stopped working around 2/17/25

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V 754	Continued From page 81 - The handyman that repaired it recommended the entire unit be replaced but he had not replaced it yet because of the cost - The handyman was able to get the heating system working again but it stopped working again "about 2 weeks ago" - The handyman looked at the unit last week and it should be repaired on 3/20/25 or 3/21/25 Interview on 3/25/25 the Owner/Admin/QP reported: - He owned the facility and was responsible for all repairs and maintenance - The heating system impacted the downstairs heat of the facility - The heating system upstairs and the air conditioning was on a separate system and they were working - The heating unit would have to be replaced and was not able to be repaired - The cost would be $8000-$9000 and he had to decide on a unit - He did not have a time frame for when that would be completed Interviews on 4/10/25 and 4/17/25 the Owner/Admin/QP reported: - He was "still shopping around for the heat and trying to find something that is more affordable" - He had only used the facility's heating repairman for repairs to the heating system - "I suppose that it's (the heating system) been out since January (2025)" - The facility had been using space heaters while the heating system had not been working - He had not had the money for the new heating system This deficiency is cross referenced into 10A	V 754		

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V 754	Continued From page 82 NCAC 27G .0203 Competencies of Qualified Professionals and Associate Professionals (V109) for a Type A1 rule violation and must be corrected within 23 days.	V 754		