Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL001-232	A. BUILDING: ______ B. WING ______	R 09/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHANGING LIVES FAMILY CARE HOME, LLC	207 AARONS WAY BURLINGTON, NC 27217

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 000	INITIAL COMMENTS An annual and follow up survey was completed on September 25, 2025. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600A Supervised Living for Adults with Mental Illness. This facility is licensed for 5 and has a current census of 5. The survey sample consisted of audits of 3 current clients.	V 000		
V 112	27G .0205 (C-D) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (c) The plan shall be developed based on the assessment, and in partnership with the client or legally responsible person or both, within 30 days of admission for clients who are expected to receive services beyond 30 days. (d) The plan shall include: (1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement; (2) strategies; (3) staff responsible; (4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both; (5) basis for evaluation or assessment of outcome achievement; and (6) written consent or agreement by the client or responsible party, or a written statement by the provider stating why such consent could not be obtained.	V 112	RECEIVED NOV 05 2025 DHSR-MH Licensure Sect	

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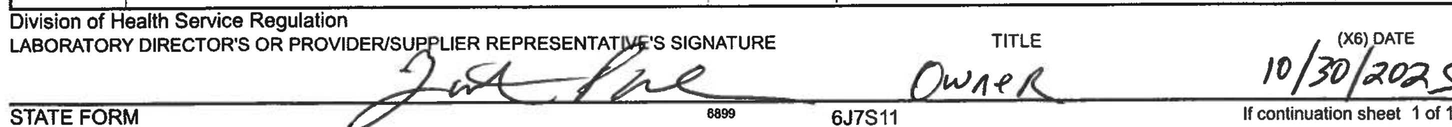

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Owner | (X6) DATE: 10/30/2025

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V 112	Continued From page 1 This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to schedule a review of a plan at least annually affecting three of three audited clients (#1, #2 and #3). The findings are: Review on 9/24/25 of client #1's record revealed: -Admission date of 8/28/13. -Diagnoses of Schizoaffective Disorder-bipolar type, Hypertension, Oppositional Defiant Disorder, Nicotine Dependence and Chronic Viral Hepatitis. -Person Centered Plan (PCP) dated 7/16/24. -There was no documentation of a current plan. Review on 9/24/25 of client #2's record revealed: -Admission date of 7/30/20. -Diagnosis of Schizophrenia. -PCP dated 6/16/24. -There was no documentation of a current plan. Review on 9/24/25 of client #3's record revealed: -Admission date of 12/16/19. -Diagnoses of Schizophrenia, Tobacco Use Disorder, Cannabis Use Disorder and Hallucinogen Use Disorder. -PCP dated 11/8/23. -There was no documentation of a current plan. Interview on 9/25/25 with the Qualified Professional (QP) revealed: -She was responsible for completing the clients	V 112		

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V 112	Continued From page 2 PCPs. -She had copies of the clients most current PCPs on a flash drive. -"I have not gotten around to coming by the facility to put the clients PCPs in the record books." Interview on 9/25/25 with the Executive Director/Co-Licensee revealed: -He wasn't aware of PCP's not being current. -The QP was responsible for completing the clients PCPs. -He confirmed the facility failed to schedule a review of a plan at least annually for clients #1, #2 and #3.	V 112		
V 114	27G .0207 Emergency Plans and Supplies 10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES (a) Each facility shall develop a written fire plan and a disaster plan and shall make a copy of these plans available to the county emergency services agencies upon request. The plans shall include evacuation 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.	V 114		

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V 114	Continued From page 3	V 114		

This Rule is not met as evidenced by:
Based on record review and interviews, the facility failed to ensure fire and disaster drills were conducted quarterly and on each shift. The findings are:

Review on 9/25/25 of the facility's fire and disaster drill log from October 2024-September 2025 revealed:
-There were no fire or disaster drills completed by weekend staff for the 2nd quarter (April, May, June) of 2025.
-There were no fire or disaster drills completed for the 1st quarter (January, February, March) of 2025.
-There were no fire or disaster drills completed for the 4th quarter (October, November, December) of 2024.

Interview on 9/24/25 with client #1 revealed:
-They walked to the mailbox for fire drills.
-They went into the bathroom in the hallway for disaster drills.

Interview on 9/24/25 with client #2 revealed:
-He was not sure if they did fire and disaster drills with staff.

Interview on 9/24/25 with client #3 revealed:
-They walked outside and to the mailbox for fire drills.
-They all went into the bathroom in the hallway for the disaster drills.

Interview on 9/25/25 with the Qualified Professional (QP) revealed:
-She was responsible for checking to ensure staff completed fire and disaster drills.
-"We had some staff changes for weekend staff and those staff had not been doing drills."

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V 114	Continued From page 4 -She confirmed the facility failed to ensure fire and disaster drills were conducted quarterly on each shift Interview on 9/25/25 with the Executive Director/Co-Licensee revealed: -He was aware that the weekend shift staff should have been doing fire and disaster drills quarterly. -The QP was responsible for ensuring staff were doing drills. -"I thought [QP]was keeping an eye on those drills, she should have caught that." -He confirmed the facility failed to ensure fire and disaster drills were conducted quarterly on each shift.	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 recorded immediately after administration. The MAR is to include the following: (A) client's name;	V 118		

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V 118	Continued From page 5	V 118		

(B) name, strength, and quantity of the drug;
(C) instructions for administering the drug;
(D) date and time the drug is administered; and
(E) name or initials of person administering the drug.
(5) Client requests for medication changes or checks shall be recorded and kept with the MAR file followed up by appointment or consultation with a physician.

This Rule is not met as evidenced by:
Based on record review and interviews, the facility failed to keep the MAR current affecting one of three audited clients (#2). The findings are:

Reviews on 9/24/25 and 9/25/25 of client #2's record revealed:
-Admission date of 7/30/20.
-Diagnosis of Schizophrenia.
-Physician's order dated 6/30/25 for Haloperidol 5 mg (Schizophrenia), two tablets in the morning
Haloperidol 5 mg, three tablets at bedtime
Benztropine 1 mg (Involuntary movements), one tablet twice a day
Divalproex 500 mg, two tablets at bedtime
Metoprolol 25 mg (Hypertension), one tablet twice daily
-Physician's order dated 11/25/24 for Divalproex 500 mg, one tablet in the morning
Aripiprazole 15 mg (Schizophrenia), one tablet daily

Review on 9/24/25 of client #2's August 2025 MAR revealed:

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V 118	Continued From page 6 No staff initials to indicate the medication was administered for the following: -Haloperidol 5 mg on 8/2 thru 8/4 am doses and 8/1 thru 8/3 pm doses -Benztropine 1 mg on 8/2 thru 8/4 am doses and 8/1 thru 8/3 pm doses -Divalproex 500 mg on 8/2 thru 8/4 am doses and 8/1 thru 8/3 pm doses -Metoprolol 25 mg on 8/2 thru 8/4 am doses and 8/1 thru 8/3 pm doses -Aripiprazole 15 mg on 8/2 thru 8/4 Interview on 9/24/25 with staff #1 revealed: -Staff #3 worked on those days in August 2025 when client #2's MAR was not signed off. -"[Staff #3] was newer and possibly forgot to sign the MAR." -Staff #3 gave client #2 his medication in August 2025. -"There were no issues with the medication count being incorrect in August." -She confirmed the MAR was not kept current for client #2. Interview on 9/25/25 with the Executive Director/Co-Licensee confirmed: -The MAR was not kept current for client #2.	V 118		
V 121	27G .0209 (F) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (f) Medication review: (1) If the client receives psychotropic drugs, the governing body or operator shall be responsible for obtaining a review of each client's drug regimen at least every six months. The review shall be to be performed by a pharmacist or	V 121		

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physician. The on-site manager shall assure that the client's physician is informed of the results of the review when medical intervention is indicated.
(2) The findings of the drug regimen review shall be recorded in the client record along with corrective action, if applicable.

This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to obtain drug regimen reviews every six months for three of three audited clients (#1, #2 and #3) who received psychotropic drugs. The findings are:

Reviews on 9/24/25 and 9/25/25 of client #1's record revealed:
-Admission date of 8/28/13.
-Diagnoses of Schizoaffective Disorder-bipolar type, Hypertension, Oppositional Defiant Disorder, Nicotine Dependence and Chronic Viral Hepatitis.
-Physician's order dated 2/3/25 for Aripiprazole 15 milligrams (mg) (Schizoaffective Disorder), one half tablet daily
Clozapine 200 mg, (Schizoaffective Disorder), two tablets at bedtime
Trazodone 100 mg (Anxiety), three tablets at bedtime
-A drug regimen review was completed on 3/29/22.
-There was no documentation of a drug regimen review completed within the last six months.

Review on 9/25/25 of the September 2025 Medication Administration Record (MAR) revealed:

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V 121	Continued From page 8 -Staff documented client #1 was administered the above medication on 9/1 thru 9/24. Reviews on 9/24/25 and 9/25/25 of client #2's record revealed: -Admission date of 7/30/20. -Diagnosis of Schizophrenia. -Physician's order dated 6/30/25 for Haloperidol 5 mg (Schizophrenia), two tablets in the morning Haloperidol 5 mg, three tablets at bedtime Benztropine 1 mg (Involuntary movements), one tablet twice a day Divalproex 500 mg, two tablets at bedtime -Physician's order dated 11/25/24 for Divalproex 500 mg, one tablet in the morning Aripiprazole 15 mg (Schizophrenia), one tablet daily -A drug regimen review was completed on 3/29/22. -There was no documentation of a drug regimen review completed within the last six months. Review on 9/25/25 of the September 2025 MAR revealed: -Staff documented client #2 was administered the above medication on 9/1 thru 9/24. Reviews on 9/24/25 and 9/25/25 of client #3's record revealed: -Admission date of 12/16/19. -Diagnoses of Schizophrenia, Tobacco Use Disorder, Cannabis Use Disorder and Hallucinogen Use Disorder. -Physician's order dated 11/7/24 for Mirtazapine 15 mg (Major Depressive Disorder), one tablet at bedtime -Physician's order dated 9/26/24 for Paliperidone Extended Relief 3 mg (Schizophrenia), one tablet daily Propranolol 20 mg (Anxiety), one tablet twice	V 121		

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V 121	Continued From page 9 daily -A drug regimen review was completed on 3/29/22. -There was no documentation of a drug regimen review completed within the last six months. Review on 9/25/25 of the September 2025 MAR revealed: -Staff documented client #3 was administered the above medication on 9/1 thru 9/24. Interview on 9/24/25 with staff #1 revealed: -"Someone came out to do a drug regimen review last year." -"I did not recall seeing anyone do a drug regimen review this year." -She confirmed there was no documentation of a drug regimen review completed for clients #1, #2 and #3 within the last six months. Interview on 9/25/25 with the Executive Director/Co-Licensee revealed: -The pharmacy staff normally did the drug regimen reviews every 3 months for the clients at the facility. -He wasn't sure why the drug regimen reviews were never completed by the pharmacy staff. -He confirmed there was no documentation of a drug regimen review completed for clients #1, #2 and #3 within the last six months.	V 121		
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.	V 290		

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V 290	Continued From page 10 (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 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.	V 290		

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This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to review the plan annually to ensure clients continue to be capable of remaining in the home or community without supervision for specified periods of time for two of three audited clients (#1 and #3). The findings are:

Reviews on 9/24/25 and 9/25/25 of client #1's record revealed:
-Admission date of 8/28/13.
-Diagnoses of Schizoaffective Disorder-bipolar type, Hypertension, Oppositional Defiant Disorder, Nicotine Dependence and Chronic Viral Hepatitis.
-Unsupervised time assessment dated 4/13/21-"He can use up to 2-3 hours."
-No documentation that client #1's plan was reviewed annually to ensure he remained capable of unsupervised time in the home and community without supervision.

Reviews on 9/24/25 and 9/25/25 of client #3's record revealed:
-Admission date of 12/16/19.
-Diagnoses of Schizophrenia, Tobacco Use Disorder, Cannabis Use Disorder and Hallucinogen Use Disorder.
-Unsupervised time assessment dated 8/1/24-He had up to 2-3 hours of unsupervised time.
-No documentation that client #3's plan was reviewed annually to ensure he remained capable of unsupervised time in the home and community without supervision.

Interview on 9/24/25 with client #1 revealed:

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Continued From page 12

-He had unsupervised in the home and community.
-"Most of the time staff is at the facility, so I really don't use the unsupervised time at home."
-"I will occasionally go out in the community without staff."

Interview on 9/24/25 with client #3 revealed:
-"I really didn't use the unsupervised time at home because staff were there most of the time."
-He goes out in the community with a friend most of the time.
-He goes out unsupervised in the community "2-3 times a week."

Interview on 9/24/25 with staff #1 revealed:
-Clients #1 and #3 had unsupervised at the facility and in the community.
-Client #1 goes out in the community unsupervised "occasionally."
-Client #3 was allowed to go out in the community with a friend.
-Clients #1 and #3 "would occasionally" stay at the facility unsupervised.

Interview on 9/25/25 with the Qualified Professional (QP) revealed:
-She was responsible for doing the clients' unsupervised time assessments.
-She was not aware the unsupervised time assessments had to be done annually.
-"I thought the unsupervised assessments were only updated if there were changes."
-She confirmed clients #1 and #3's plans were not reviewed annually to ensure they remained capable of unsupervised time in the home or community without supervision.

Interview on 9/25/25 with the Executive Director/Co-Licensee revealed:

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V 290	Continued From page 13 -Clients #1 and #3 had unsupervised time in home and community. -"They don't use their unsupervised time too often." -The QP was responsible for doing the unsupervised time assessments for clients. -He confirmed clients #1 and #3's plans were not reviewed annually to ensure they remained capable of unsupervised time in the home or community without supervision.	V 290		
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 observation and interviews, the facility and its grounds were not maintained in a clean, attractive, orderly manner and kept free from offensive odor. The findings are: Observation on 9/24/25 of the facility at approximately 1:30 pm revealed: -Kitchen area-There were grease stains and food debris on the refrigerator, stove, deep freezer and cabinets. -Bathroom in clients #1 and #5's bedroom-The window had a crack approximately 10 inches long. Another crack was approximately 2 feet long. There were blue and white toothpaste stains in the sink. The toilet rim, lid and seat had rust stains, hair and dirt on them. The inside of the tub was peeling. Both bathroom rugs had dark stains. -Bathroom in hallway-The wall behind the toilet	V 736		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL001-232	A. BUILDING: ______ B. WING ______	R 09/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHANGING LIVES FAMILY CARE HOME, LLC	207 AARONS WAY BURLINGTON, NC 27217

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V 736	Continued From page 14 had peeling paint. The light fixture was rusted and had a build up of dirt. -Clients #3 and #4's bedroom-Strong musty odor. Outside of the door had grayish/brownish stains -Outside area-A wooden fence near front of the facility was leaning and separated from the post. On the side of the facility there was a glass storm door, a door screen, 2 broken wooden chairs and a metal intravenous (IV) bag holder. Interview on 9/24/25 with staff #1 revealed: -She talked with the Executive Director (ED)/Co-Licensee about most of the issues with the facility. -"Someone came out and made some of the repairs." -She talked with the clients about cleaning the facility. -She acknowledged all of the above issues with the facility. Interview on 9/25/25 with the ED/Co-Licensee revealed: -He came to the facility "once a week or more." -He normally looked to see if there are any issues with the facility whenever he visited. -"The window in that bathroom has gotten worse, initially there was a small crack." -Staff #1 had not said anything to him about those issues with the facility. -He acknowledged all of the above issues with the facility. This deficiency has been cited two time(s) since the original cite on 10/17/23 and must be corrected within 30 days.	V 736		

→ V000

• **Element**	• **Description**
• **1. Measures to Correct the Action** *(What we did/will do immediately to fix the specific error.)*	• **Action:** Providing the State with a proactive Action Plan following Annual Survey.
• **2. Measures to Prevent Recurrence** *(What permanent changes we made to stop this from happening again.)*	• **Action:** To establish corrections lasting the lifetime of the facilities.
• **3. Who Will Monitor the Situation** *(The individual responsible for oversight.)*	• **Responsible Party:** Executive Director, Program Manager, Qualified Professional (QP)
• **4. Monitoring Frequency** *(How often the monitoring will occur to ensure sustained compliance.)*	• **Frequency:** Annually **Initial Phase (3 months):** The Program Director will conduct a 100% audit of all client quarterly assessments immediately upon completion. **Ongoing Phase (after 3 months):** Audit frequency will shift to a random review of 50% of completed quarterly assessments monthly, recorded in the supervision log.

Action	Responsible Party	Deadline
Complete and Submit the POA	Executive Director	**10 days** from the receipt date of the letter.
Correct Re-cited Deficiencies	Program Manager, Qualified Professional (QP), & Staff	**30 days** from the survey exit date (September 25, 2025).
Correct All Other Deficiencies	Program Manager, Qualified Profession (QP) & Staff	**60 days** from the survey exit date (September 25, 2025).
Sign and Date Form	Executive Director	Before submission (within the 10-day period).

Resolution:

The immediate corrective action involves retroactively completing and documenting all missing portions of the required assessments for the affected clients. To prevent recurrence, all staff will be retrained on the Quarterly Assessment Policy, and a mandatory, standardized checklist will be implemented to ensure all required elements are met before filing. The Program Director will be designated as the responsible party for monitoring the situation. Monitoring will occur in an initial phase with a 100% audit of all new assessments for three months, followed by an ongoing phase of monthly random reviews.

→ V112

Element	Action
1. Measures to Correct the Action *(Immediate, retrospective steps to fix the specific errors)*	**Action:** The Qualified Professional (QP) will immediately print, date, and file the most current Person-Centered Plans (PCPs) for Clients #1, #2, and #3 into their respective client record books. The **Executive Director/Co-Licensee** will perform a **100% audit** of these three records to confirm the current PCPs are physically present and signed/dated. The QP will immediately schedule the next annual PCP review for all three clients, ensuring the next date is within one year of the current PCP's effective date, and document this schedule in the client record.
2. Measures to Prevent Recurrence *(Systemic, forward-looking changes to policy/procedure/training)*	**Policy/Procedure Change:** The facility will implement a **PCP Annual Review Tracking Log** for all clients. This log will be maintained in a central location and reviewed weekly by the Executive Director. **Training:** The QP and Executive Director will be trained on the **PCP Completion and Documentation Policy**, which mandates that the completed, signed PCP must be filed in the client's record book **within 24 hours** of the completion date. The QP will no longer rely solely on a personal flash drive for official client records. **Accountability:** The Executive Director is now responsible for ensuring the QP completes and files the PCP and schedules the next review **at least 30 days prior** to the client's annual review due date.

Element	Action
3. Who Will Monitor the Situation *(The individual responsible for oversight)*	**Responsible Party:** The **Executive Director/Co-Licensee**.
4. Monitoring Frequency *(How often the monitoring will occur to ensure sustained compliance)*	**Initial Phase (90 days):** The Executive Director will audit **100%** of all active client records on the **1st and 15th of every month** to verify the presence of a current, signed PCP and the documentation of the next scheduled annual review date. **Ongoing Phase (After 90 days):** The Executive Director will review the centralized **PCP Annual Review Tracking Log weekly** and perform a **monthly random audit of 50%** of client records to ensure compliance with the filing and scheduling procedure.

Resolution:

The immediate correction involves the QP printing and filing the current Person-Centered Plans (PCPs) for all three clients and scheduling their next annual reviews, with the Executive Director (ED) auditing these three records. To prevent recurrence, the facility will implement a centralized PCP Annual Review Tracking Log, and the QP and ED will be retrained on a strict 24-hour filing mandate to stop reliance on unfiled personal copies. The Executive Director is designated as the sole responsible party for monitoring the situation. The ED will monitor by performing bi-monthly 100% audits for 90 days, followed by weekly reviews of the tracking log and monthly 50% random audits thereafter.

→ V114

Element	Action
1. Measures to Correct the Action *(Immediate, retrospective steps to fix the specific errors and knowledge gaps)*	**Drill Completion:** The Executive Director will immediately ensure that all staff shifts (Day, Evening, Night/Weekend) conduct and document a **make-up fire drill and a make-up disaster drill** within **7 days**. These drills must be conducted under conditions that simulate facility response to actual emergencies (e.g., blocked exits, noise). **Staff Training:** All staff, especially weekend staff, will receive immediate retraining on the **Emergency Drill Policy**, emphasizing the **quarterly requirement for *each shift***, proper drill simulation techniques (not just walking to the mailbox), and the required documentation procedure.
2. Measures to Prevent Recurrence *(Systemic, forward-looking changes to policy/procedure/training)*	**New Policy/Tool:** A **Mandatory Monthly Emergency Drill Schedule and Log** will be created. This log will list the required drill dates for each quarter, separated by shift (Day, Evening, Weekend). The QP will be required to initial this log weekly to verify compliance, and the Executive Director will co-sign it monthly. **Accountability:** The responsibility for *completing* the drill remains with the **direct care staff on shift**. The responsibility for *ensuring and documenting* the drill completion is assigned jointly to the **Qualified Professional (QP)** and the **Executive Director/Co-Licensee**. The QP must provide verbal and written reminders to staff at the start of each quarter.

Element	Action
3. Who Will Monitor the Situation *(The individual responsible for oversight)*	**Responsible Party:** The **Executive Director/Co-Licensee** (for overall compliance and log review) and the **Qualified Professional (QP)** (for checking staff completion).
4. Monitoring Frequency *(How often the monitoring will occur to ensure sustained compliance)*	**Initial Phase (90 days):** The Executive Director will review the **Monthly Emergency Drill Schedule and Log weekly every Monday** to ensure all required drills for the previous week were completed and correctly documented by the respective shift staff. **Ongoing Phase (After 90 days):** The Executive Director will review the log **monthly** to ensure quarterly compliance by all shifts. Any missed drills will trigger immediate staff retraining and documented coaching.

Resolution:

The immediate corrective action requires the Executive Director (ED) to ensure all staff shifts conduct and document make-up fire and disaster drills within seven days, utilizing realistic simulation conditions. To prevent recurrence, a Mandatory Monthly Emergency Drill Schedule and Log will be implemented, and all staff will receive immediate retraining on the quarterly, per-shift requirements and documentation procedures. Monitoring responsibility is assigned jointly to the ED for overall compliance and the Qualified Professional (QP) for verifying shift completion. The ED will conduct a weekly review of the drill log for 90 days, shifting to a monthly review thereafter to ensure sustained quarterly compliance across all shifts.

→ V118

Element	Action
1. Measures to Correct the Action *(Immediate, retrospective steps to fix the specific errors and documentation gaps)*	**Documentation Correction:** Staff will immediately review the August 2025 MAR for client#1, #2, and #3. Staff will retrospectively initial all missing administration slots confirmed to have been given, adding a notation (e.g., "Retrospectively signed on 9/25/25 per ED request") in the MAR comments section to account for the late signing. **Staff Retraining:** All staff responsible for medication administration will immediately attend a remedial training session focused solely on the **"Immediate Documentation"** requirement of the MAR, reinforcing that initials must be marked **immediately after** the medication is administered.
2. Measures to Prevent Recurrence *(Systemic, forward-looking changes to policy/procedure/training)*	**Policy Change:** The facility's Medication Administration Policy will be updated to include a **"Two-Check MAR Verification"** procedure: 1) The administering staff initials the MAR immediately. 2) The administering staff verbally confirms with the departing staff member during shift change that the current shift's MAR has been completed and signed off. **Supervision/New Staff Procedure:** New or temporary staff (like Staff at the time) will be required to have a **medication "shadow period"** for their first five shifts where an experienced staff member audits their MAR documentation in real-time. **Medication Kit Upgrade:** Implement a visible physical tool (e.g., a bright yellow sticky flag) that must be placed on the current day's MAR until it is fully initialed, serving as a visual cue to staff.

Element	Action
3. Who Will Monitor the Situation *(The individual responsible for oversight)*	**Responsible Party:** The **Qualified Professional (QP)** (for daily MAR checks) and the **Executive Director/Co-Licensee** (for overall system audit).
4. Monitoring Frequency *(How often the monitoring will occur to ensure sustained compliance)*	**Initial Phase (90 days):** The QP will conduct a **100% audit of all client MARs at the start of every shift (morning, evening, and weekend)** to ensure the previous shift's documentation is complete and current. The QP will initial a separate **MAR Audit Log** confirming this check. **Ongoing Phase (After 90 days):** The Executive Director will conduct a **random audit of 50% of client MARs** and review the MAR Audit Log **weekly** to ensure the QP is performing their oversight duties consistently.

Resolution:

The immediate corrective action requires staff to retrospectively initial all missing August 2025 Medication Administration Record (MAR) slots for the affected clients and attend remedial training on the requirement for immediate documentation. To prevent recurrence, the facility will implement a "Two-Check MAR Verification" procedure during shift change, enhance supervision for new staff, and utilize visual cues like sticky flags on the current day's MAR. Monitoring responsibility is shared between the Qualified Professional (QP) for daily checks and the Executive Director (ED) for overall system audits. The QP will perform a 100% MAR audit at the start of every shift for 90 days, after which the ED will conduct weekly audits of the MAR Audit Log and random MAR reviews.

V121

Element	Action
1. Measures to Correct the Action *(Immediate, retrospective steps to fix the specific errors)*	**Immediate DRR Scheduling:** The Executive Director will immediately contact the consulting pharmacist or the clients' primary prescribing physicians and arrange for an urgent, comprehensive drug regimen review (DRR) for Clients #1, #2, and #3. This review must be completed **within 7 days. Documentation:** Upon receipt of the DRR findings, the Executive Director will ensure the findings and any required corrective actions are immediately recorded and filed in the client records and that prescribing physicians are informed of any required medical intervention.
2. Measures to Prevent Recurrence *(Systemic, forward-looking changes to policy/procedure/training)*	**New Policy/Tool:** The facility will implement a **Psychotropic Drug Regimen Review (DRR) Tracker**. This is a centralized log listing the client's name, start date of psychotropic medication, the last DRR date, and the **next required DRR due date** (6 months from the last review). **Contractual/Systemic Change:** The Executive Director will establish a formal, written agreement with the consulting pharmacist or pharmacy service provider mandating that DRRs are conducted and documented **quarterly (every 3 months)**—exceeding the 6-month minimum requirement—to provide a buffer against scheduling delays. **Accountability:** The Executive Director will retain ultimate responsibility for ensuring the DRR is scheduled and completed on time.

Element	**Action**
3. Who Will Monitor the Situation *(The individual responsible for oversight)*	**Responsible Party:** The **Executive Director/Co-Licensee**.
4. Monitoring Frequency *(How often the monitoring will occur to ensure sustained compliance)*	**Initial Phase (90 days):** The Executive Director will review the **DRR Tracker weekly** to ensure the immediate reviews are completed and filed, and to confirm all clients have their next review date correctly scheduled. **Ongoing Phase (After 90 days):** The Executive Director will review the DRR Tracker **monthly** and generate a scheduling alert **45 days** before any client's DRR is due. This 45-day lead time ensures the appointment can be secured, conducted, and the results documented well before the 6-month regulatory deadline is reached.

Resolution:

The immediate correction requires the Executive Director (ED) to arrange an urgent, comprehensive Drug Regimen Review (DRR) for all three affected clients with a pharmacist or physician, which must be completed and filed within seven days. To prevent recurrence, the facility will implement a centralized DRR Tracker and establish a formal contract mandating that reviews are conducted quarterly, exceeding the required six-month frequency. The Executive Director is designated as the sole party ultimately responsible for monitoring and accountability. Monitoring will involve the ED reviewing the DRR Tracker weekly for 90 days, then shifting to a monthly review with a scheduling alert generated 45 days prior to any required review date.

→ V290

Element	Action
1. Measures to Correct the Action *(Immediate, retrospective steps to fix the specific errors and documentation gaps)*	**Immediate Assessment:** The Qualified Professional (QP) will immediately conduct and document the required annual review of the unsupervised time capabilities for Clients #1 and #3. This review will confirm if they remain capable of using their currently approved unsupervised time (2-3 hours). **Documentation Filing:** The completed and signed review documentation will be filed in the client records **within 24 hours** of completion. **Staff Training:** The QP will be immediately retrained by the Executive Director on the specific language of **10A NCAC 27G .5602(b)**, which mandates the review be done **at least annually** to ensure capability continues.
2. Measures to Prevent Recurrence *(Systemic, forward-looking changes to policy/procedure/training)*	**New Policy/Tool:** The facility will integrate the Unsupervised Time Review into the existing **PCP Annual Review Tracking Log** (created in response to V 0205). A dedicated column will be added, labeled "Unsupervised Time Review Due Date," set to exactly 12 months from the last review date. **Procedural Mandate:** The QP must complete the Unsupervised Time Review **concurrently** with the annual Person-Centered Plan (PCP) review, or as a minimum, **within 30 days** of the last review's anniversary date. This links two mandatory annual tasks to prevent oversight. **Staff Communication:** All staff will be informed that the legal authorization for a client to be unsupervised relies on this current annual documentation.

Element	Action
3. Who Will Monitor the Situation *(The individual responsible for oversight)*	**Responsible Party:** The **Executive and** The Qualified Professional (QP) **Director/Co-Licensee**.
4. Monitoring Frequency *(How often the monitoring will occur to ensure sustained compliance)*	**Initial Phase (90 days):** The Executive Director will audit the **PCP/Unsupervised Time Review Tracker weekly** to ensure that all required annual assessments are scheduled and completed on time for all clients. **Ongoing Phase (After 90 days):** The Executive Director will check the Tracker **monthly** and physically verify the documentation in the client record for any client whose Unsupervised Time Review is due within the next **45 days**, providing a sufficient buffer to complete the task before the annual deadline.

Resolution:

The immediate corrective action requires the Qualified Professional (QP) to immediately conduct, document, and file the annual review of unsupervised time capabilities for the affected clients and receive retraining on the mandatory annual review requirement. To prevent recurrence, the facility will integrate the Unsupervised Time Review into a centralized tracking log and mandate that the QP complete this review concurrently with the annual Person-Centered Plan (PCP). The Executive Director is designated as the primary party responsible for monitoring this process. Monitoring will involve the ED auditing the tracking log weekly for 90 days, then shifting to monthly reviews with verification checks 45 days before any client's annual review is due.

→ V736

Element	Action
1. Measures to Correct the Action *(Immediate, retrospective steps to fix the specific physical and sanitation problems)*	**Immediate Deep Clean & Remediation (Within 48 hours):** The facility will hire a professional cleaning service or dedicate staff time to complete a full deep clean of the kitchen area (refrigerator, stove, freezer, cabinets) and the bathroom in clients #1 and #5's bedroom (remove rust, hair, dirt from toilet, clean sink, discard stained rugs). **Immediate Repairs (Within 7 days):** The Executive Director (ED) will contract and schedule the following repairs: 1) Replace the cracked window in the bathroom. 2) Repair the peeling paint in the bathroom. 3) Replace the rusted light fixture. 4) Repair/Replace the leaning wooden fence and remove all debris from the side of the facility (glass door, screen, broken chairs, IV holder). **Odor Elimination:** Address the source of the strong musty odor in clients #3 and #4's bedroom (e.g., check for leaks, excessive moisture, or improper ventilation) and treat the area to eliminate the odor.
2. Measures to Prevent Recurrence *(Systemic, forward-looking changes to maintenance and cleanliness protocols)*	**Maintenance Checklists:** Implement a **Daily Sanitation Checklist** for kitchen and high-traffic bathrooms (completed and signed by shift staff) and a **Weekly Deep Clean & Safety Audit Checklist** (completed and signed by the QP). **Mandatory Reporting Policy:** Update the staff policy to require **immediate verbal and written reporting** of facility safety hazards (e.g., cracked window, leaning fence) to the Executive Director. Failure to report hazards will result in disciplinary action. **ED Weekly Audit:** The Executive Director must dedicate **one full hour during their weekly visit** solely to performing a comprehensive facility safety and sanitation audit, documented on a new **ED Maintenance Log**.

Element	Action
3. Who Will Monitor the Situation *(The individual responsible for oversight)*	**Responsible Party:** The **Executive Director/Co-Licensee** (for maintenance and structural safety) and the **Qualified Professional (QP)** (for daily sanitation and odor control).
4. Monitoring Frequency *(How often the monitoring will occur to ensure sustained compliance)*	**Initial Phase (30 days - Due to Re-cite):** The Executive Director will visit the facility **every 48 hours** to verify the ongoing cleanliness and repair progress, using the new ED Maintenance Log. **Ongoing Phase (After 30 days):** The QP will review and sign the **Daily Sanitation Checklists** before leaving their shift. The Executive Director will conduct a formal facility audit, recorded on the **ED Maintenance Log, weekly every Friday**, to ensure sustained maintenance, cleanliness, and safety.

Resolution:

The immediate correction requires a professional deep clean of the kitchen and bathroom within 48 hours, followed by the Executive Director contracting all necessary repairs (e.g., window, paint, fence) within seven days. To prevent recurrence, the facility will implement Daily Sanitation Checklists for staff and a new mandatory policy for the immediate reporting of safety hazards, alongside a dedicated Weekly Deep Clean & Safety Audit Checklist completed by the QP. Monitoring responsibility is shared between the Executive Director (ED) for maintenance and the Qualified Professional (QP) for daily sanitation checks. Due to the re-citation, the ED will visit every 48 hours for 30 days, then transition to a formal weekly facility audit every Friday to ensure sustained compliance.