

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 180011	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 B. WING _____	(X3) DATE SURVEY COMPLETED R 05/08/2024
NAME OF PROVIDER OR SUPPLIER LYRA FAMILY CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 503 QUAKER DELL LANE CARY, NC 27519		
(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
C 000	Initial Comments Report by Jonathan Gamsey DHSR Construction Section conducted a Biennial Follow-up Survey on May 8, 2024 from 10:50 AM to 11:30 AM at the above-referenced facility. At the time of the survey, not all deficiencies were corrected therefore further action is required. Additional deficiencies were also observed. NOTES: 1.) At the time of our visit, we cited deficiencies that require an acceptable plan of correction. All deficiencies listed were discussed with onsite staff during the exit interview. There were previous deficiencies that were not closed out from an open biennial survey, these deficiencies were brought forward from the previous survey. 2.) Take actions to correct all listed deficiencies, once completed provide verification in the form of photos, receipts, invoices, etc. for all work performed. The cited deficiencies are as follows:	C 000		
C 911	G.S 131D 21(1) Declaration of Resident's Rights G.S. 131D-21 Declaration of Resident's Rights Every resident shall have the following rights: (1) To be treated with respect, consideration, dignity, and full recognition of his or her individuality and right to privacy. This Rule is not met as evidenced by: 1.) At the time of the survey, it was observed that two camera monitors were in the living room that viewed bedrooms. This is not compliant with the rule. Take the necessary steps to only allow	C 911	Monitor waiver forms attached to corrections report indicate that POA gave permission for staff to view monitors for supervision and safety purposes. Monitors have been relocated to a staff only location out of sight of public visitors, signs were placed on each door to warn about video/audio monitoring in progress.	05/22/2024

Division of Health Service Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

Administrator

(X6) DATE

05/30/2024

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 180011	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 B. WING _____	(X3) DATE SURVEY COMPLETED R 05/08/2024
NAME OF PROVIDER OR SUPPLIER LYRA FAMILY CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 503 QUAKER DELL LANE CARY, NC 27519		
(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
C 911	Continued From page 1 access to the camera feed to just family members and provide written permission from the family to DHSR.	C 911		
{C 174}	Building Equipment Maintained Safe, Operating SECTION .0300 - THE BUILDING 10A NCAC 13G .0317 BUILDING SERVICE EQUIPMENT (a) The building and all fire safety, electrical, mechanical, and plumbing equipment in a family care home shall be maintained in a safe and operating condition. (j) This Rule shall apply to new and existing family care homes. This Rule is not met as evidenced by: 1.) At the time of the survey, it was observed that the fire sprinkler head in the dining room had a penetration hole in the ceiling exposing an opening that could allow the spread of smoke and heat. This is not compliant with the rule. Take the necessary steps to ensure that the sprinkler head and escutcheon plate are working as intended. 2.) At the time of the survey, it was observed that other fire sprinkler head-concealed escutcheon had started to drop. This is not compliant with the rule. Take the necessary steps to repair, it is recommended to utilize a certified professional to set the escutcheon back in its original state.	{C 174}	Sprinkler maintenance company came out and resolved all cited deficiencies. See attached statement of job completion.	05/28/2024

RESIDENT MONITORING TECHNOLOGY DEVICE CONSENT

Resident: Linda Cox

Facility: Valo Place at Heritage Pines

Electronic Technology Device Information

Make/Brand: Hello Baby

Characteristics of Device: (Check all that apply)

- ☐ Device is capable of capturing video
- ☐ Device is capable of capturing audio
- ☐ Device is capable of recording audio
- ☐ Device is capable of recording video
- ☐ Device is capable of being activated remotely

If device records or streams, who will have access? List the name(s)/relationships of these who will have access: device does not record

Identify the intended use of the monitoring device: Safety monitoring

Identify the intended hours of operation of the monitoring device: during sleep hours

Identify the location of the monitoring device in the Resident's room: bedroom dresser

Understanding

I acknowledge and understand that:

- As the Resident I can request to stop use of the electronic monitoring device in my room at any time.
- No person can access any video or audio monitoring created through my monitoring device without my written consent.
- I agree that the video/audio monitoring device can be monitored by staff to ensure my safety.
- I agree that the use of the video/audio monitoring device is not violation of my privacy rights.

Signature

By signing my name below:

I consent to place and use a monitoring technology device that allows video/audio access in my room or living unit.

Signature of Resident: _____ Date: _____

If a Representative is signing on behalf of the Resident:

Print POA/Representative Name: Laura A Parker

Relationship to Resident: daughter

Signature POA/Representative: Laura A Parker Date: 10/16/2020

See Reverse Side For Withdrawing Consent

RESIDENT MONITORING TECHNOLOGY DEVICE CONSENT

Resident: Joseph Kass

Facility: Vals Place at Heritage Pines

Electronic Technology Device Information

Make/Brand: Hello Baby

Characteristics of Device: (Check all that apply)

- ☐ Device is capable of capturing video
- ☐ Device is capable of capturing audio
- ☐ Device is capable of recording audio
- ☐ Device is capable of recording video
- ☐ Device is capable of being activated remotely

If device records or streams, who will have access? List the name(s)/relationships of these who will have access: Device does not record

Identify the intended use of the monitoring device: safety monitoring

Identify the intended hours of operation of the monitoring device: during sleep hours

Identify the location of the monitoring device in the Resident's room: bedroom dresser

Understanding

I acknowledge and understand that:

- As the Resident I can request to stop use of the electronic monitoring device in my room at any time.
- No person can access any video or audio monitoring created through my monitoring device without my written consent.
- I agree that the video/audio monitoring device can be monitored by staff to ensure my safety.
- I agree that the use of the video/audio monitoring device is not violation of my privacy rights.

Signature

By signing my name below:

I consent to place and use a monitoring technology device that allows video/audio access in my room or living unit.

Signature of Resident: _____ Date: _____

If a Representative is signing on behalf of the Resident:

Print POA/Representative Name: Douglas Kass

Relationship to Resident: SON

Signature POA/Representative: [Signature] Date: 4-13-2023

See Reverse Side For Withdrawing Consent

RESIDENT MONITORING TECHNOLOGY DEVICE CONSENT

Resident: Lee Kass

Facility: Vals Place at Heritage Pines

Electronic Technology Device Information

Make/Brand: Hello Baby

Characteristics of Device: (Check all that apply)

- ☐ Device is capable of capturing video
- ☐ Device is capable of capturing audio
- ☐ Device is capable of recording audio
- ☐ Device is capable of recording video
- ☐ Device is capable of being activated remotely

If device records or streams, who will have access? List the name(s)/relationships of these who will have access: Device does not record

Identify the intended use of the monitoring device: safety monitoring

Identify the intended hours of operation of the monitoring device:

during sleep hours

Identify the location of the monitoring device in the Resident's room:

bedroom dresser

Understanding

I acknowledge and understand that:

- As the Resident I can request to stop use of the electronic monitoring device in my room at any time.
- No person can access any video or audio monitoring created through my monitoring device without my written consent.
- I agree that the video/audio monitoring device can be monitored by staff to ensure my safety.
- I agree that the use of the video/audio monitoring device is not violation of my privacy rights.

Signature

By signing my name below:

I consent to place and use a monitoring technology device that allows video/audio access in my room or living unit.

Signature of Resident: _____ Date: _____

If a Representative is signing on behalf of the Resident:

Print POA/Representative Name: Douglas Kass

Relationship to Resident: SON

Signature POA/Representative: [Signature] Date: 4-11-2023

See Reverse Side For Withdrawing Consent