STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE ( A. BUILDING:	CONSTRUCTION		E SURVEY PLETED	
		MHL001-251	B. WING	<del></del>	04	/26/2018
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATI	E, ZIP CODE	·	
LILLIES P	I ACE #2	121 HAZ	EL DRIVE			
LILLIES P	LACE #2	BURLIN	GTON, NC 27217			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
V 000	INITIAL COMMENTS		V 000			
	2018. There were def	d for the following service				
	Supervised Living for	Adults with Mental Illness				
V 112	27G .0205 (C-D) Assessment/Treatme	nt/Habilitation Plan	V 112			
	PLAN (c) The plan shall be assessment, and in p legally responsible per of admission for clien receive services beyond (d) The plan shall incompose the projected date of achieved by provision projected date of achieved by strategies; (3) staff responsible; (4) a schedule for reannually in consultation responsible person of the projected date of achieved by strategies; (3) staff responsible; (4) a schedule for reannually in consultation responsible person of the projected date of achievement (b) written consent of the projected date of the projected date of the projected date of achievement (e) written consent of the projected date	developed based on the artnership with the client or erson or both, within 30 days ts who are expected to and 30 days. Blude: I that are anticipated to be a of the service and a dievement; I view of the plan at least on with the client or legally roboth; I to on or assessment of				

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		MHL001-251	B. WING		04/26/2018	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
		121 HAZE	L DRIVE			
LILLIES P	LACE #2		TON, NC 27217	,		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N (x	(5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMF	PLETE ATE
V 112	Continued From page	2 1	V 112			
	This Rule is not met as evidenced by: Based on record reviews and interview, the facility failed to develop a treatment plan for one of three audited clients (#1). The findings are:  Review on 4/26/18 of Client #1's record revealed: -Admission date of 11/20/17Diagnoses of Attention Deficit Hyperactivity Disorder, Conduct Disorder, Unspecified Developmental Disability and Seizure DisorderThere was no treatment plan in client's record.  Interview on 4/26/18 with the Administrative Assistant revealed: -The Qualified Professional was responsible for completing treatment plansConfirmed there was no treatment plan for client #1 in the recordThe treatment plan should have been completed within 30 days after admitted to the facility.					
V 114	27G .0207 Emergeno	y Plans and Supplies	V 114			
	AND SUPPLIES  (a) A written fire plan area-wide disaster plashall be approved by authority.  (b) The plan shall be and evacuation proceposted in the facility.  (c) Fire and disaster contains the held at least repeated for each shi under conditions that	an shall be developed and				

Division of Health Service Regulation

STATE FORM 6899 CRR911 If continuation sheet 2 of 8

	FATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _	A. BUILDING:		
		MHL001-251	B. WING		04/2	6/2018
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
LILLIES P	I ACF #2	121 HAZE	L DRIVE			
		BURLING	TON, NC 27217	7	Т	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETE DATE
V 114	Continued From page	2	V 114			
V 133	failed to conduct fire a shift at least quarterly Review on 4/26/18 of disaster drills record refere was a fire drill 2nd shift, 12/1/17 - 1s shift.  -There was a disaster 2nd shift.  -There was a disaster 2nd shift.  -There were no fire at at least quarterly on each 1 least quarterly on each 26/18 of Assistant revealed:  -Confirmed the fire are conducted at least quested at le	ew and interview the facility and disaster drills on each and disaster drills on each the facility's fire and evealed: conducted on 10/31/17 - st shift and 3/12/18 - 2nd or drill conducted on 3/15/18 - and disaster drills conducted each shift.  with the Administrative and disaster drills were not arterly on each shift.  at a fire and disaster drill regulation.  al History Record Check  INAL HISTORY RECORD FOR CERTAIN IMPLOYMENT. ed in this section, the term	V 133			
	program and any providevelopmental disabiliservices that is licens Chapter.  (b) Requirement Arprovider licensed und	an area authority/county vider of mental health, lity, and substance abuse able under Article 2 of this n offer of employment by a er this Chapter to an tion that does not require the				

Division of Health Service Regulation

STATE FORM 6899 CRR911 If continuation sheet 3 of 8

PRINTED: 04/27/2018 FORM APPROVED

Division of Health Service Regulation

Division of Fleath Service Regulation						
STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY			
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	COMPLETED			
		B WING				
	MHL001-251	B. WING	04/26/2018			
NAME OF PROVIDED OR OURRUSE	OTDEET ADDI	DEGO CITY OTATE ZID CODE				
NAME OF PROVIDER OR SUPPLIER	STREET ADDI	RESS, CITY, STATE, ZIP CODE				

NAME OF F		DDRESS, CITY, STATE	E, ZIP CODE	
LILLIES I	PLACE #2	EL DRIVE		
	BURLING	GTON, 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 133	Continued From page 3	V 133		
	applicant to have an occupational license is conditioned on consent to a State and national criminal history record check of the applicant. If the applicant has been a resident of this State for less than five years, then the offer of employment is conditioned on consent to a State and national criminal history record check of the applicant. The national criminal history record check shall include a check of the applicant's fingerprints. If the applicant has been a resident of this State for five years or more, then the offer is conditioned on consent to a State criminal history record check of the applicant. A provider shall not employ an applicant who refuses to consent to a criminal history record check required by this section. Except as otherwise provided in this subsection, within five business days of making the conditional offer of employment, a provider shall submit a request to the Department of Justice under G.S. 114-19.10 to conduct a criminal history record check required by this section or shall submit a request to a private entity to conduct a State criminal history record check required by this section. Notwithstanding G.S. 114-19.10, the Department of Justice shall return the results of national criminal history record checks for employment positions not covered by Public Law 105-277 to the Department of Health and Human Services, Criminal Records Check Unit. Within five business days of receipt of the national criminal history of the person, the Department of Health and Human Services, Criminal Records Check Unit, shall notify the provider as to whether the information received may affect the employability of the applicant. In no case shall the results of the national criminal history record check be shared with the provider. Providers shall make available upon request verification that a criminal history			

Division of Health Service Regulation

STATE FORM 6899 CRR911 If continuation sheet 4 of 8

DIVISION	of Health Service Regu	liation			_
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
			1	_	
			B. WING		
		MHL001-251	15		04/26/2018
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE	
		121 HAZ	EL DRIVE		
LILLIES P	LACE #2	BURLING	STON, NC 27217	7	
24.1.1=	CUMMADV CT	ATEMENT OF DEFICIENCIES			N 0.50
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD	( - /
TAG	,	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPI	
				DEFICIENCY)	
V 133	Continued From page	2.4	V 133		
V 133	Continued From page	= 4	V 133		
	check has been comp	pleted on any staff covered			
	by this section. A cou	inty that has adopted an			
	appropriate local ordi	nance and has access to			
	the Division of Crimin	al Information data bank			
	may conduct on beha	alf of a provider a State			
	criminal history record	d check required by this			
		ovider having to submit a			
		ment of Justice. In such a			
	-	I commence with the State			
		d check required by this			
	section within five but				
		nployment by the provider.			
		formation received by the			
	-	al and may not be disclosed,			
		nt as provided in subsection			
	(c) of this section. For	The state of the s			
		"private entity" means a			
	business regularly en				
	9	d checks utilizing public			
	records obtained fron	- ·			
		licant's criminal history			
		one or more convictions of			
		e provider shall consider all			
		s in determining whether to			
	hire the applicant:	account of the swime			
	• •	ousness of the crime.			
	(2) The date of the cr				
		rson at the time of the			
	conviction.	a accompany alice of the -			
	(4) The circumstance				
	commission of the cri				
	• •	en the criminal conduct of			
	·	b duties of the position to be			
	filled.				
	(6) The prison, jail, pr				
		ployment records of the			
		e the crime was committed.			
	(7) The subsequent of	commission by the person of			
	a relevant offense.				

Division of Health Service Regulation

STATE FORM 6899 CRR911 If continuation sheet 5 of 8

PRINTED: 04/27/2018 FORM APPROVED

Division of Health Service Regulation

DIVISION	n nealth Service Regu	lation			
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
		MHL001-251	B. WING	<del></del>	04/26/2018
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE ZIP CODE	
TWANE OF TH	NOVIDER OR OUT FEEL			(IL, ZII GOBE	
LILLIES P	LACE #2	121 HAZE		_	
		BURLING	TON, NC 27217	7	
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	( - )
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	
TAG	REGULATORT OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	NATE
				,	
V 133	Continued From page	5	V 133		
	The feet of conviction	of a relevant offense alone			
		of a relevant offense alone			
		employment; however, the			
		considered by the provider.			
	-	ifies an applicant after			
		elevant factors, then the			
		information contained in			
		cord check that is relevant			
		but may not provide a copy			
	of the criminal history	record check to the			
	applicant.				
	• ,	- A provider and an officer			
		vider that, in good faith,			
		ction shall be immune from			
	civil liability for:				
	(1) The failure of the	provider to employ an			
	individual on the basis	s of information provided in			
		cord check of the individual.			
	(2) Failure to check a	n employee's history of			
	criminal offenses if the	e employee's criminal			
	history record check i	s requested and received in			
	compliance with this s	section.			
	(e) Relevant Offense.	- As used in this section,			
	"relevant offense" me	ans a county, state, or			
	federal criminal histor	y of conviction or pending			
	indictment of a crime,	whether a misdemeanor or			
	felony, that bears upo	on an individual's fitness to			
		the safety and well-being of			
		ital health, developmental			
		nce abuse services. These			
		minal offenses set forth in			
		rticles of Chapter 14 of the			
		cle 5, Counterfeiting and			
	Issuing Monetary Sub				
		ve and Legislative Officers;			
	•	rticle 7A, Rape and Other			
		8, Assaults; Article 10,			
		ction; Article 13, Malicious			
	Injury or Damage by U				
	incentially Device of	Material; Article 14, Burglary			

Division of Health Service Regulation

STATE FORM 6899 CRR911 If continuation sheet 6 of 8

PRINTED: 04/27/2018 FORM APPROVED

Division c	of Health Service Regu	ılation			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
		MHL001-251	B. WING		04/26/2018
NAME OF DE	DOWNER OR SURRULER	QTDEET A	DDDESS CITY STAT	TE 710 CODE	·
NAIVIE OF 1 1	ROVIDER OR SUPPLIER		DDRESS, CITY, STAT	IE, ZIP CODE	
LILLIES P	LACE #2		EL DRIVE	,	
		GTON, NC 27217			
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES  BY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	( - /
TAG	,	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE	
				DEFICIENCY)	
V 133	Continued From page	e 6	V 133		
		akings; Article 15, Arson and			
		le 16, Larceny; Article 17,			
	,	Embezzlement; Article 19,			
	False Pretenses and	r Services by False or			
		redit Device or Other Means;			
		I Transaction Card Crime			
	·	s; Article 21, Forgery; Article			
	26, Offenses Against				
	_	, Adult Establishments;			
		n; Article 28, Perjury; Article			
		1, Misconduct in Public			
	Office; Article 35, Office	enses Against the Public			
		Riots and Civil Disorders;			
	Article 39, Protection				
	Protection of the Fam				
	· ·	cle 60, Computer-Related			
		also include possession or			
	_	tion of the North Carolina			
		es Act, Article 5 of Chapter			
		atutes, and alcohol-related			
	violation of G.S. 18B-	e to underage persons in			
		of G.S. 20-138.1 through			
	G.S. 20-138.5.	71 G.G. 20-130.1 tillough			
		ning False Information Any			
		nent who willfully furnishes,			
		e gives false information on			
		cation that is the basis for a			
	criminal history record	d check under this section			
		ass A1 misdemeanor.			
		oyment A provider may			
	employ an applicant of	• •			
	_	of a criminal history record			
		applicant if both of the			
	following requirement				
		I not employ an applicant			
	prior to obtaining the	applicant's consent for			

Division of Health Service Regulation

criminal history record check as required in

STATE FORM 6899 CRR911 If continuation sheet 7 of 8

STATEMENT OF DEFICIENCIES (X		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
ANDILAN	or connection	IDENTIFICATION NOIMBEN.	A. BUILDING:		COMI LETED	
		MHL001-251	B. WING		04/26/2018	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
LILLIES P	LACE #2	121 HAZEI				
	I		TON, NC 27217		1	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE	
	fingerprint cards as re (2) The provider shall criminal history record business days after the conditional employme 2001-155, s. 1; 2004-2005-4, ss. 1, 2, 3, 4,  This Rule is not met Based on record revie failed to ensure the st was ordered within five the conditional offer of three audited staff (#*	ent. (2000-154, s. 4; 124, ss. 10.19D(c), (h); 5(a); 2007-444, s. 3.)  as evidenced by: ew and interview, the facility rate criminal record check we business days of making of employment for one of 1). The findings are:				
	revealed: - Hire date: 11/6/17 - Job title: Paraprof - The criminal recor 11/22/17.  During interview on 4. Administrative Assista criminal record check business days of con- She reported the Adm	fessional/Part-time. d check was ordered				

Division of Health Service Regulation

STATE FORM 6899 CRR911 If continuation sheet 8 of 8