Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BUILDING:		
		MHL020-082	B. WING		04/13/2018
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, STA	TE, ZIP CODE	
THE RIVE	R HOUSE	284 SMOK MURPHY,	EFORD ROAD NC 28906		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE
V 000	INITIAL COMMENTS		V 000		
	Deficiencies were cite  This facility is license category: 10A NCAC	s completed on 4/13/18. ed. d for the following service 27G .5600C Supervised of all Disability Groups.		RECEIVED  By MH Lic & Cert Section at 11:32 am, May 1	0, 2018
V 114	V 114 27G .0207 Emergency 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 ashall be held at least repeated for each shi under conditions that	an shall be developed and			
	failed to conduct disa shift. The findings are Review on 4/13/18 of revealed: -No documentation of second tour shift, We for the 3rd quarter of	ew and interview the facility ster drills quarterly on each e: the facility disaster drills f a B drill which was the dnesday 8am-Friday 4pm		IDD Operations Manager will of spreadsheet to track all required and disaster drills for each qual IDD Operations Manager will of that staff complete all required per shift.	ed fire arter. ensure

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

TITLE (X6) DATE Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING:		(X3) DATE COMP		
		MHL020-082	B. WING		04/	13/2018
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	E, ZIP CODE		
THE RIVE	R HOUSE	284 SMC	OKEFORD ROAD			
		MURPH	Y, NC 28906			_
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
V 114	Continued From page	e 1	V 114			
	was to go in the bath Interview on 4/13/18 revealed: -The facility had 3 tou and CHe was aware of the	ed tornado drills. I was conduct the process room and cover your head. with the Operations Manager our shifts, designated as A, B e requirement to do drills on				
V/ 11Q	each shiftThe staff failed to pe 27G .0209 (C) Medic	erform the drill as required.	V 118			
	10A NCAC 27G .020 REQUIREMENTS (c) Medication admin (1) Prescription or no only be administered order of a person aut drugs. (2) Medications shall clients only when aut client's physician. (3) Medications, inclu- administered only by unlicensed persons tr pharmacist or other le privileged to prepare (4) A Medication Adm all drugs administere current. Medications recorded immediately MAR is to include the (A) client's name; (B) name, strength, a (C) instructions for ac (D) date and time the	9 MEDICATION  istration: on-prescription drugs shall to a client on the written chorized by law to prescribe  be self-administered by chorized in writing by the  uding injections, shall be licensed persons, or by rained by a registered nurse, egally qualified person and and administer medications. ninistration Record (MAR) of d to each client must be kept administered shall be y after administration. The				

Division of Health Service Regulation

STATE FORM 6899 205X11 If continuation sheet 2 of 9

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			_			
		MHL020-082	B. WING		04/1	3/2018
NAME OF P	ROVIDER OR SUPPLIER		RESS, CITY, STA	•		
THE RIVE	R HOUSE	284 SMOK MURPHY,	EFORD ROAD NC 28906			
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
V 118	checks shall be recor file followed up by ap with a physician.	r medication changes or ded and kept with the MAR pointment or consultation	V 118			
	failed to maintain the prescription drugs we by the physician for 1 The findings are:  Review on 4/12/18 ar Client #3 revealed: -Admission date of 3/ Moderate Intellectual Disorder, Unspecified Control Disorder, Bor Rhinitis and Gastro e-Physician order date 50mcg 1 spray each	and record review the facility MAR current and ensure re administered as ordered of 3 sampled clients (#3).  and 4/13/18 of the record for 27/18 with diagnoses of Disability, Major Depressive Schizophrenia, Impulse derline Diabetes, Allergic sophageal Reflux Disease. d 3/28/18 for Flonase nostril daily.		The Director of IDD Services will all medication orders to the MAF make any necessary changes to orders on the MAR upon receiving signed orders for residents.	R and existing	
	2018 MAR revealed: -March 27-31 include each nostril daily as r Interview on 4/12/18 v -She received her me doctorShe was not aware of Interview on 4/12/18 v Operations Manager	with Client #3 revealed: dications as directed by the of any missed medication. and 4/13/18 with the				

Division of Health Service Regulation

STATE FORM 6899 205X11 If continuation sheet 3 of 9

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING:			(X3) DATE SURVEY COMPLETED		
		MHL020-082	B. WING		04/13/2018
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	ATE, ZIP CODE	
THE DIVE	R HOUSE	284 SMC	KEFORD ROAD		
INE KIVE	IK HOUSE	MURPH'	Y, NC 28906		
(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 SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE
V 118	Continued From page	: 3	V 118		
	daily on 3/28/18He initially thought th	e order for Flonase daily 4/1/18 and the MAR was			
V 133	G.S. §122C-80 CRIM CHECK REQUIRED I APPLICANTS FOR E (a) Definition As use "provider" applies to a program and any providevelopmental disabil services that is licens Chapter. (b) Requirement An provider licensed und applicant to fill a posit applicant to have an o conditioned on conse criminal history record the applicant has bee less than five years, t is conditioned on conse criminal history record national criminal histor include a check of the the applicant has bee five years or more, th on consent to a State check of the applicant employ an applicant of criminal history record section. Except as oth subsection, within five the conditional offer of	MPLOYMENT.  ed in this section, the term an area authority/county vider of mental health, lity, and substance abuse able under Article 2 of this  a offer of employment by a er this Chapter to an ion that does not require the occupational license is not to a State and national dicheck of the applicant. If n a resident of this State for then the offer of employment sent to a State and national dicheck of the applicant. The sent to a State and national dicheck of the applicant. The sent to a State and national dicheck of the splicant. The in a resident of this State for en the offer is conditioned criminal history record	V 133	ncgCARE Human Resources serequest an application for employment from new staff which includes information on years they've lived in NC. If stalived in NC less than 5 years, to will be given a fingerprint card orientation. The card will be mades' parent company ncgCAF send to NC SBI to be processoresults will be kept in the employersonnel file.	how many aff have the staff during ailed to RE to ed. The

Division of Health Service Regulation

STATE FORM 6899 205X11 If continuation sheet 4 of 9

Division of	of Health Service Regu	lation				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SUR	RVEY
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETE	ED
			D WING			
		MHL020-082	B. WING		04/13/2	2018
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
		284 SMC	KEFORD ROAD			
THE RIVE	R HOUSE		r, NC 28906			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	N	(X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	RIATE	DATE
				DEI IGIENCI)		
V 133	Continued From page	e 4	V 133			
	looting on deep 0.0.44	4 40 40 to sometiment				
	Justice under G.S. 11					
		d check required by this				
		it a request to a private				
	-	ate criminal history record				
		s section. Notwithstanding				
	·	Department of Justice shall				
		ational criminal history				
		ployment positions not				
	covered by Public Lav					
	Department of Health	and Human Services,				
	Criminal Records Che	eck Unit. Within five				
	business days of rece	eipt of the national criminal				
	history of the person,	the Department of Health				
		, Criminal Records Check				
	Unit, shall notify the p	provider as to whether the				
		may affect the employability				
	of the applicant. In no	case shall the results of the				
	national criminal histo	ory record check be shared				
	with the provider. Pro	viders shall make available				
	upon request verificat	tion that a criminal history				
	check has been comp	oleted on any staff covered				
	by this section. A cou	nty that has adopted an				
	appropriate local ordi	nance and has access to				
		al Information data bank				
	•	ılf of a provider a State				
	criminal history record	d check required by this				
	section without the pr	ovider having to submit a				
	request to the Depart	ment of Justice. In such a				
		I commence with the State				
	criminal history record	d check required by this				
	section within five bus	siness days of the				
	conditional offer of en	nployment by the provider.				
	All criminal history inf	ormation received by the				
	provider is confidentia	al and may not be disclosed,				
	except to the applicar	nt as provided in subsection				
	(c) of this section. For	•				
		private entity" means a				

Division of Health Service Regulation

business regularly engaged in conducting criminal history record checks utilizing public

STATE FORM 6899 If continuation sheet 5 of 9 205X11

Division of Health Service Regulation

MHL020-082  MHL020-082  STREET ADDRESS, CITY, STATE, ZIP CODE	018
- U4/13/20	018
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS CITY STATE 7IP CODE	
OTTLET ADDITION, OTTLET, ALL CODE	
THE RIVER HOUSE 284 SMOKEFORD ROAD	
MURPHY, NC 28906	
PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CO	(X5) OMPLETE DATE
V 133 Continued From page 5 V 133	
records obtained from a State agency. (c) Action If an applicant's criminal history record check reveals one or more convictions of a relevant offense, the provider shall consider all of the following factors in determining whether to hire the applicant:  (1) The level and seriousness of the crime. (2) The date of the crime. (3) The age of the person at the time of the conviction. (4) The circumstances surrounding the commission of the crime, if known. (5) The nexus between the criminal conduct of the person and the job duties of the position to be filled. (6) The prison, jail, probation, parole, rehabilitation, and employment records of the person since the date the crime was committed. (7) The subsequent commission by the person of a relevant offense. The fact of conviction of a relevant offense alone shall not be a bar to employment; however, the listed factors shall be considered by the provider. If the provider disqualifies an applicant after consideration of the relevant factors, then the provider may disclose information contained in the criminal history record check to the applicant. (d) Limited Immunity A provider and an officer or employee of a provider that, in good faith, complies with this section shall be immune from civil iliability for: (1) The failure of the provider to employ an individual on the basis of information provided in the criminal history record check of the individual. (2) Failure to check an employee's history of	

Division of Health Service Regulation

STATE FORM 6899 205X11 If continuation sheet 6 of 9

Division of	of Health Service Regu	lation			
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
ANDILAN	SI CONNECTION	IDENTIFICATION NOMBER.	A. BUILDING: _		COWII ELTED
		MIII 000 000	B. WING		0.4/40/0040
		MHL020-082	B. WING		04/13/2018
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STA	FE, ZIP CODE	
THE RIVE	R HOUSE		KEFORD ROAD		
		MURPHY	, NC 28906		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
V 133	Continued From page	e 6	V 133		
	history record check i	s requested and received in			
	compliance with this	-			
		As used in this section,			
		ans a county, state, or			
		ry of conviction or pending			
		whether a misdemeanor or			
	felony, that bears upon an individual's fitness to have responsibility for the safety and well-being of				
		ital health, developmental			
	· -	nce abuse services. These			
		minal offenses set forth in			
	any of the following A	rticles of Chapter 14 of the			
		icle 5, Counterfeiting and			
	Issuing Monetary Sub				
		ve and Legislative Officers;			
		article 7A, Rape and Other			
		8, Assaults; Article 10, action; Article 13, Malicious			
	Injury or Damage by				
		Material; Article 14, Burglary			
	_	akings; Article 15, Arson and			
		le 16, Larceny; Article 17,			
	_	Embezzlement; Article 19,			
	False Pretenses and				
	Obtaining Property or				
		edit Device or Other Means;			
	· ·	Transaction Card Crime			
		s; Article 21, Forgery; Article			
	26, Offenses Against				
	j .	, Adult Establishments; n; Article 28, Perjury; Article			
		, Misconduct in Public			

Division of Health Service Regulation

Office; Article 35, Offenses Against the Public Peace; Article 36A, Riots and Civil Disorders; Article 39, Protection of Minors; Article 40, Protection of the Family; Article 59, Public Intoxication; and Article 60, Computer-Related Crime. These crimes also include possession or sale of drugs in violation of the North Carolina

STATE FORM 6899 205X11 If continuation sheet 7 of 9

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C			E SURVEY PLETED	
		MHL020-082	B. WING		04	/13/2018
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STATE	E, ZIP CODE		
THE RIVE	R HOUSE		KEFORD ROAD 7, NC 28906			
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	ΓΙΟΝ SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
V 133	Controlled Substance 90 of the General Sta offenses such as sale violation of G.S. 18B-impaired in violation of G.S. 20-138.5.  (f) Penalty for Furnish applicant for employn supplies, or otherwise an employment applic criminal history record shall be guilty of a Cla (g) Conditional Employemploy an applicant of obtaining the results of check regarding the afollowing requirement (1) The provider shall prior to obtaining the criminal history record subsection (b) of this fingerprint cards as re (2) The provider shall criminal history record business days after the conditional employme 2001-155, s. 1; 2004-	is Act, Article 5 of Chapter tutes, and alcohol-related to underage persons in 302 or driving while of G.S. 20-138.1 through the two willfully furnishes, a gives false information on cation that is the basis for a dicheck under this section ass A1 misdemeanor. The argument of a criminal history record applicant if both of the sare met:  Inot employ an applicant applicant's consent for dicheck as required in section or the completed equired in G.S. 114-19.10. Submit the request for a dicheck not later than five the individual begins	V 133			
	failed to submit the re record check to include five business days aff	ew and interview the facility quest for a criminal history de fingerprints no later than ter the individual begins ent for 1 of 3 sampled staff				

Division of Health Service Regulation

STATE FORM 6899 205X11 If continuation sheet 8 of 9

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		SURVEY PLETED	
		MHL020-082	B. WING		04	/13/2018
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STAT	TE, ZIP CODE		
THE RIVE	R HOUSE		KEFORD ROAD , NC 28906			
(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 C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
V 133	Continued From page	8	V 133			
	Staff #1 revealed: -Hire date of 4/3/17Staff #1 had lived in a yearsThe criminal backgrothe submission of fing Interview on 4/13/18 of Director revealed: -She was not sure who submitted for Staff #1-She was not providin background requirem hiredShe was aware of the	with the Human Resources  by the fingerprints were not  congression of the ents when Staff #1 was  e requirement for anel who was a resident of				

Division of Health Service Regulation

STATE FORM 6899 205X11 If continuation sheet 9 of 9