STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL001-142	A. BUILDING: _____ B. WING _____	R 05/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
L & J HOMES- APPLE STREET	816 APPLE STREET BURLINGTON, NC 27216

(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 May 3, 2018. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G. 5600C Supervised Living for Adults with Developmental Disabilities.	V 000		
V 110	27G .0204 Training/Supervision Paraprofessionals 10A NCAC 27G .0204 COMPETENCIES AND SUPERVISION OF PARAPROFESSIONALS (a) There shall be no privileging requirements for paraprofessionals. (b) Paraprofessionals shall be supervised by an associate professional or by a qualified professional as specified in Rule .0104 of this Subchapter. (c) Paraprofessionals shall demonstrate knowledge, skills and abilities required by the population served. (d) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence. (e) 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. (f) The governing body for each facility shall develop and implement policies and procedures for the initiation of the individualized supervision plan upon hiring each paraprofessional.	V 110		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL001-142	A. BUILDING: _____ B. WING _____	R 05/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
L & J HOMES- APPLE STREET	816 APPLE STREET BURLINGTON, NC 27216

(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 110	Continued From page 1 This Rule is not met as evidenced by: Based on record review and interviews the facility failed to ensure one of three audited staff (#1) demonstrated knowledge, skills and abilities for population served. The findings are: Review on 4/27/18 of Staff #1's record revealed: - Hire date of 11/29/76 as Direct Care Worker - Documentation the staff's most recent medication training occurred on 4/20/18. The staff was required to retake the training in response to a medication error which occurred when he did not follow the facility's medication administration procedure. Review on 4/26/18 of Client #1's record revealed: - Admission date of 5/4/10 - Diagnoses of Bipolar Disorder with manic episodes; Mild Mental Retardation; Gastroesophageal Reflux Disease; and Type II Diabetes Mellitus. Review on 4/26/18 of the Staff #1's personnel file and the facility's incident reports revealed the following: - Staff #1 prepared morning medications for Client #1 and Client #2. - The staff placed all of Client #1's morning medications in a container. He also placed all of Client #2's morning medications in a container. - Staff #1 placed both containers of medication on the kitchen counter. - Client #1 requested his glucose test strips to check his blood sugar. - Staff #1 went to the medication closet to	V 110		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL001-142	A. BUILDING: _____ B. WING _____	R 05/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
L & J HOMES- APPLE STREET	816 APPLE STREET BURLINGTON, NC 27216

(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 110	Continued From page 2	V 110		

respond to Client #1's request.
- The medication in the containers remained unattended and unsecured when he left the area to go to the medication closet in a separate room.
- While Staff #1 was in the other room with the medication closet, Client #1 went to the kitchen counter and consumed the medications prepared for Client #2.
- He consumed the following medications: Flomax 0.4mg, Lamictal 25mg, Depakote 500mg, Rexulti 1mg, Vesicare 10mg, Aspirin 81mg, Lipitor 40mg, Claritin 10mg, Colace 100mg 2 tablets, Senna 8.6mg 2 tablets, Klonopin 1mg, Congentin 1mg, Amitiza 24mcg.
- Staff returned to the kitchen to discover Client #1 had consumed Client #2's medications.
- Staff followed the facility's Medication Administration policy and contacted the Registered Nurse.
- He also contacted Poison Control per the nurse's direction.

Interview on 5/1/18 with the Facility's Qualified Professional revealed:
- Client #1 was taken to the emergency room for further evaluation.
- The emergency room medical staff did not find Client #1 experienced any negative effects from the taking medication.
- The client was closely monitored for the next 24 hours.
- Facility management has taken steps to respond to and correct the problem.
- Staff #1 was suspended and had to be retrained on medication administration.
- Facility management has also taken additional steps to assure staff receive regular supervision and training.

This deficiency constitutes a re-cited deficiency

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL001-142	A. BUILDING: _____ B. WING _____	R 05/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
L & J HOMES- APPLE STREET	**816 APPLE STREET BURLINGTON, NC 27216**

(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 110	Continued From page 3 and must be corrected within 30 days.	V 110		