STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED				
			71. 501251110.		R			
	MHL001-142		B. WING		05/03/2018			
NAME OF	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
L & J HC	L & J HOMES- APPLE STREET BURLINGTON, NC 27216							
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTI	ON	(X5)		
PRÉFIX TAG		MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)		COMPLETE DATE		
V 000	INITIAL COMMENT	rs	V 000					
		w up survey was completed eficiencies were cited.						
	category: 10A NCA	sed for the following service C 27G. 5600C Supervised h Developmental Disabilities.						
V 110	27G .0204 Training Paraprofessionals	/Supervision	V 110					
	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.							

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

(X6) DATE TITLE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
					R	
		MHL001-142	B. WING			3/2018
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
L & J HC	MES- APPLE STREE	T	E STREET	2040		
	OUR # 44 DV OTA		TON, NC 27		211	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	.D BE	(X5) COMPLETE DATE
V 110	Continued From page 1		V 110			
	failed to ensure one	et as evidenced by: view and interviews the facility e of three audited staff (#1) vledge, skills and abilities for				
	population served.					
	- Hire date of 11/29 - Documentation the medication training was required to retain a medication error of the medication error	of Staff #1's record revealed: /76 as Direct Care Worker e staff's most recent occurred on 4/20/18. The staff ake the training in response to which occurred when he did y's medication administration				
	 Admission date of Diagnoses of Bipo episodes; Mild Men 	olar Disorder with manic				
	and the facility's incomposition following: - Staff #1 prepared Client #1 and Client - The staff placed a medications in a conclient #2's morning - Staff #1 placed both the kitchen counter - Client #1 requested the check his blood suggested.	ill of Client #1's morning intainer. He also placed all of medications in a container. oth containers of medication on . ed his glucose test strips to				

Division of Health Service Regulation

STATE FORM 6899 TRX911 If continuation sheet 2 of 4

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				DATE SURVEY COMPLETED	
			A. BUILDING.		F	,	
		MHL001-142	B. WING	·····		3/2018	
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
L & J HC	L & J HOMES- APPLE STREET 816 APPL BURLING			216			
(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 CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
V 110	respond to Client # - The medication in unattended and un to go to the medication closet, counter and consumed the Flomax 0.4mg, Lar Rexulti 1mg, Vesical Lipitor 40mg, Clarit tablets, Senna 8.6m Congentin 1mg, Ar - Staff returned to the #1 had consumed - Staff followed the Administration polication. Interview on 5/1/18 Professional revea - Client #1 was take further evaluation. Interview on 5/1/18 Professional revea - Client #1 was take further evaluation. The emergency reclient #1 experience the taking medication. The client was closures. Facility managem respond to and cor - Staff #1 was suspon medication adm - Facility managem steps to assure stall and training.	at the containers remained secured when he left the area ation closet in a separate room. It is in the other room with the Client #1 went to the kitchen med the medications prepared of following medications: mictal 25mg, Depakote 500mg, are 10mg, Aspirin 81mg, in 10mg, Colace 100mg 2 mg 2 tablets, Klonopin 1mg, mitiza 24mcg. The kitchen to discover Client Client #2's medications. If acility's Medication by and contacted the discover Client with the Facility's Qualified led: The medical staff did not find the company med	V 110				

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STATE FORM 6899 TRX911 If continuation sheet 3 of 4

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL001-142		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE COME	(X3) DATE SURVEY COMPLETED	
		B. WING			R 05/03/2018	
NAME OF I	PROVIDER OR SUPPLIER	STREET A		STATE, ZIP CODE		
L & J HC	MES- APPLE STREE	I .	LE STREET GTON, NC 27	7216		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
V 110	V 110 Continued From page 3		V 110			
	and must be correct	ted within 30 days.				

6899

Division of Health Service Regulation STATE FORM