

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL051-173	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 05/17/2018
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SAVIN GRACE II	STREET ADDRESS, CITY, STATE, ZIP CODE 562 OLD DAM ROAD SELMA, NC 27576
---	--

(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 17, 2018. There were deficiencies cited. This facility is licensed for the following service category: 10A NCAC 27G. 1700 Residential Treatment Staff Secure for Children or Adolescents	V 000		
V 108	27G .0202 (F-I) Personnel Requirements 10A NCAC 27G .0202 PERSONNEL REQUIREMENTS (f) Continuing education shall be documented. (g) Employee training programs shall be provided and, at a minimum, shall consist of the following: (1) general organizational orientation; (2) training on client rights and confidentiality as delineated in 10A NCAC 27C, 27D, 27E, 27F and 10A NCAC 26B; (3) training to meet the mh/dd/sa needs of the client as specified in the treatment/habilitation plan; and (4) training in infectious diseases and bloodborne pathogens. (h) Except as permitted under 10a NCAC 27G .5602(b) of this Subchapter, at least one staff member shall be available in the facility at all times when a client is present. That staff member shall be trained in basic first aid including seizure management, currently trained to provide cardiopulmonary resuscitation and trained in the Heimlich maneuver or other first aid techniques such as those provided by Red Cross, the American Heart Association or their equivalence for relieving airway obstruction. (i) The governing body shall develop and implement policies and procedures for identifying, reporting, investigating and controlling infectious	V 108		

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 AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL051-173	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 05/17/2018
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SAVIN GRACE II	STREET ADDRESS, CITY, STATE, ZIP CODE 562 OLD DAM ROAD SELMA, NC 27576
---	--

(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 108	<p>Continued From page 1</p> <p>and communicable diseases of personnel and clients.</p> <p>This Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure one of three audited staff (#2) had current training in First Aid and Cardiopulmonary Resuscitation (CPR). The findings are:</p> <p>Review on 5/16/18 of Staff #2's personnel file revealed: -Hired date: 1/16/12. -Position: Paraprofessional/Hours Varied. -First Aid and CPR expired 3/15/17. -There was no evidence of a current First Aid and CPR certification.</p> <p>Interview on 5/16/18 with the Qualified Professional revealed: -She thought staff #2 completed an update of First Aid/CPR. -Staff #2 worked varies hours with another staff. -There was always two employees working on shifts with clients. -Staff #2 would be scheduled for First Aid/CPR training.</p> <p>This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.</p>	V 108		
V 736	<p>27G .0303(c) Facility and Grounds Maintenance</p> <p>10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS</p>	V 736		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL051-173	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 05/17/2018
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SAVIN GRACE II	STREET ADDRESS, CITY, STATE, ZIP CODE 562 OLD DAM ROAD SELMA, NC 27576
---	--

(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 736	<p>Continued From page 2</p> <p>(c) Each facility and its grounds shall be maintained in a safe, clean, attractive and orderly manner and shall be kept free from offensive odor.</p> <p>This Rule is not met as evidenced by: Based on observation and interview, the facility failed to ensure facility grounds were maintained in a safe and attractive manner. The findings are:</p> <p>Observation on 5/16/18 at 11:00 a.m. revealed: -In the shared bedroom, one of the beds bottom bed frame was broken. -The first bedroom to the left of the front door: -the bed frame was broken causing the mattress to be on the floor. -the closet door was crack on the bottom and off track. -the office chair arms were torn and ripped.</p> <p>Interview on 5/16/18 with the Qualified Professional revealed: -She confirmed the reported issues in client's bedrooms. -Staff #2 was responsible for monitoring and repairing all maintenance issues or concerns. -Staff #2 was paraprofessional and completed all repairs in the home.</p>	V 736		