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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
711212711	or contraction	IDENTIFICATION NOTIFICAL	A. BUILDING:		JOHN LETE	
		MHL0411155	B. WING		05/16/2018	
NAME OF PI	ROVIDER OR SUPPLIER	TE, ZIP CODE				
EMERYW	OOD HOME		RYWOOD ROA			
			ORO, NC 2740			
(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 C	(X5) COMPLETE DATE
V 000	INITIAL COMMENTS		V 000			
	An annual survey was Deficiencies were cite	s completed on 5/16/18. ed.				
	category: 10A NCAC	d for the following service 27G .5600F A Facility in a /hich Serves No More Than				
	Three Adult Clients W	/hose Primary Diagnoses is				
		ee Adult Clients or Three Primary Diagnoses is a				
	Developmental Disab					
V 118	27G .0209 (C) Medica	ation Requirements	V 118			
	10A NCAC 27G .0209	9 MEDICATION				
	REQUIREMENTS (c) Medication admini	stration:				
	(1) Prescription or no	n-prescription drugs shall				
	=	to a client on the written norized by law to prescribe				
	drugs.	ionzed by law to presenbe				
		be self-administered by				
	clients only when auticlient's physician.	norized in writing by the				
		ding injections, shall be				
		licensed persons, or by ained by a registered nurse,				
	-	egally qualified person and				
	privileged to prepare	and administer medications.				
	` '	inistration Record (MAR) of d to each client must be kept				
	current. Medications					
recorded immediately after administration. The MAR is to include the following: (A) client's name;						
	(B) name, strength, and quantity of the drug;					
	(C) instructions for ac	lministering the drug;				
		drug is administered; and person administering the				
	drug.	posson daminiotoring trio				

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			, ,	ATE SURVEY DMPLETED	
MHL0411155		B. WING		05/	16/2018		
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE			
EMERYW	OOD HOME		RYWOOD ROA				
0/0.15	CLIMMADV CT	ATEMENT OF DEFICIENCIES	BORO, NC 2740	PROVIDER'S PLAN O	E CORRECTION	0/5)	
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
V 118	Continued From page 1		V 118				
	checks shall be recor	r medication changes or ded and kept with the MAR pointment or consultation					
	administered to client immediately after adm Medication Administra	n, record review and staff failed to ensure drugs s were recorded ninistration, in client's ation Record (MAR) and tions on hand, for 1 of 1					
	Review on 5/16/18 of client #1's record revealed: -an admission date of 1/1/17; -diagnoses of Attention Deficit Hyperactivity Disorder, Mood Disorder, Oppositional Defiant Disorder, Bipolar Disorder, Moderate Intellectual Disability, and 4th Duplicate Chromosome -an order by a physician dated 4/12/18 to take Benztropine (used to treat involuntary movement) .5 milligrams twice daily.						
	take daily was availat -Benztropine and Cet 4/16/18; -Melatonin Time Rele 10 milligrams, 1-2 at l available.	revealed: rams was available; eat allergies) 10 milligrams,					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
MHL0411155		B. WING		05/16/2018	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE	
EMERYW	OOD HOME		RYWOOD ROA ORO, NC 2740		
0/0.15	STIMMADA ST	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTIO	M OVE
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
V 118	Continued From page	2	V 118		
	-Benztropine was not listed as a medication; -Cetirizine was not listed as a medication; -Melatonin was listed. Interview on 5/16/18 with the Provider revealed: -client #2's Melatonin was at his Guardian's home rather than at the facility; -he didn't think that he had to keep over the counter medications on hand at the facility; -Benztropine and Cetirizine were not on the MAR yet as the medications had been recently ordered.				
V 289	27G .5601 Supervise	d Living - Scope	V 289		
	V 289 27G .5601 Supervised Living - Scope 10A NCAC 27G .5601 SCOPE (a) Supervised living is a 24-hour facility which provides residential services to individuals in a home environment where the primary purpose of these services is the care, habilitation or rehabilitation of individuals who have a mental illness, a developmental disability or disabilities, or a substance abuse disorder, and who require supervision when in the residence. (b) A supervised living facility shall be licensed if the facility serves either: (1) one or more minor clients; or (2) two or more adult clients. Minor and adult clients shall not reside in the same facility. (c) Each supervised living facility shall be licensed to serve a specific population as designated below: (1) "A" designation means a facility which serves adults whose primary diagnosis is mental illness but may also have other diagnoses; (2) "B" designation means a facility which serves minors whose primary diagnosis is a developmental disability but may also have other				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			D. WING			
MHL0411155		B. WING		05/1	6/2018	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE		
EMERYW	OOD HOME		ERYWOOD ROA			
	OLUMBA DV OT					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
V 289	Continued From page 3		V 289			
	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) V 289 Continued From page 3 diagnoses; (3) "C" designation means a facility which serves adults whose primary diagnosis is a developmental disability but may also have other diagnoses; (4) "D" designation means a facility which serves minors whose primary diagnosis is substance abuse dependency but may also have other diagnoses; (5) "E" designation means a facility which serves adults whose primary diagnosis is substance abuse dependency but may also have other diagnoses; or (6) "F" designation means a facility in a private residence, which serves no more than three adult clients whose primary diagnoses is mental illness but may also have other disabilities, or three adult clients or three minor clients whose primary diagnoses is developmental disabilities but may also have other disabilities who live with a family and the family provides the service. This facility shall be exempt from the following rules: 10A NCAC 27G .0201 (a)(1),(2),(3),(4),(5)(A)&(B); (6); (7) (A),(B),(E),(F),(G),(H); (8); (11); (13); (15); (16); (18) and (b); 10A NCAC 27G .0202(a),(d),(g)(1) (i); 10A NCAC 27G .0203; 10A NCAC 27G .0205 (a),(b); 10A NCAC 27G .0203; 10A NCAC 27G .0205 (a),(b); 10A NCAC 27G .0207 (b),(c); 10A NCAC 27G .0304 (b)(2),(d),(4). This facility shall also be known as alternative family living or assisted family living (AFL).					
This Rule is not met as evidenced by:						

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Based on record reviews and interviews, the

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CTATEMENT OF DEFICIENCIES (VA) DROWDER/GURRUER/GUA		(VO) MULTIPLE	CONCEDUCTION	T(V2) DATE	OLIDVEY.	
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND I EAR OF CONNECTION			A. BUILDING:			
MHL0411155		B. WING		05/	16/2018	
NAME OF P	ROVIDER OR SUPPLIER	STREET AF	DRESS, CITY, STA	TE ZIP CODE		
TWINE OF T	NOVIDER OR COLL FIELD		RYWOOD ROA			
EMERYW	OOD HOME		BORO, NC 274			
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO		(X5) COMPLETE
TAG		SC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APP		DATE
				DEFICIENCY)		
V 289	Continued From page	a 1	V 289			
V 200			1 200			
		te under the scope for which				
	it was licensed affecti	ng 2 of 2 clients (clients #1				
	and #2). The findings	s are:				
	Review on 5/16/18 of					
		ras licensed for the following				
		NCAC 27G .5600F A				
		esidence, Which Serves No				
	More Than Three Adult Clients Whose Primary					
	Diagnoses is Mental Illness, or Three Adult					
	Clients or Three Minor Clients Whose Primary Diagnoses is a Developmental Disability.					
	Diagnoses is a Devel	opmental Disability.				
	Review on 5/16/18 of client #1's record revealed:					
	-an age of 22 years old;					
	-an admission date of					
		on Deficit Hyperactivity				
	_	od Disorder, Oppositional				
		olar Disorder, Moderate				
	Intellectual Developm	ental Disability and 4th				
	Duplicate Chromoson	ne.				
	Review on 5/16/18 of	client #2's record revealed:				
	-an age of 13 years o					
	-an admission date of 5/14/18;					
	-diagnoses of Autism, ADHD, Temper Tantrums,					
	Sleep Disorder, Severe Intellectual Disability;					
		Disorder of Childhood, Pica,				
		uresis, Poor Weight Gain,				
	and Skin Picking Hab	IL.				
	Interview on 5/16/10	with the Provider revealed:				
	Interview on 5/16/18 with the Provider revealed: -"I have been doing this a long time and I					
	_	g adults and children in the				
	facility;"	y addits and children in the				
-the Licensee had informed him that there were no issues with combining adults and minors in the facility.						
	Interview on 5/16/18 with the Licensee revealed:					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY PLETED	
MHL0411155		B. WING		05	5/16/2018	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE						
EMERYW	OOD HOME		ERYWOOD ROAD BORO, NC 2740			
(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 C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETE DATE
V 289	-he had been informe entity-managed care Qualified Professiona move a minor client ir already serving an ac-"there's so many rule-he had allowed clien facility as an emerger his Guardian; -"I explained to them setting was and they-a request for a waiv	ord by the local management organization and his all that he was allowed to not the facility that was full client; see and I'm still learning;" at #2 to be admitted to the not placement as a favor to [the Guardian] what my were ok with it;" er to place client #2 at the submitted to the Department	V 289			

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