STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE S COMPL	
		MHL097-045	B. WING		05/0	1/2018
	PROVIDER OR SUPPLIER	179 HOL	ADDRESS, CITY, S LY BROOK STI WILKESBORO,	REET		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY 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	(X5) COMPLE DATE
V 000	INITIAL COMMENTS	3	V 000	DHSR - Mental He	alth	
	An annual and follow on May 1, 2018. Defi	up survey was completed ciencies were cited.		MAY <b>2 4</b> 2018		
	category: 10A NCAC	d for the following service 27G .5600C Supervised Developmental Disabilities.		Lic. & Cert. Section	on	
	10A NCAC 27G .020 QUALIFIED PROFES ASSOCIATE PROFE (a) There shall be no qualified professional (b) Qualified professionals (b) Qualified professionals shall de and abilities required (c) At such time as a employment system is then qualified professionals shall de (d) Competence shall exhibiting core skills in (1) technical knowled (2) cultural awarenes (3) analytical skills; (4) decision-making; (5) interpersonal skill (6) communication sl (7) clinical skills. (e) Qualified profession NCAC 27G .0104 (18) met the requirements employment system in MH/DD/SAS. (f) The governing bood develop and implement	SSIONALS privileging requirements for s or associate professionals. ionals and associate emonstrate knowledge, skills by the population served. competency-based s established by rulemaking, ionals and associate emonstrate competence. I be demonstrated by including: dge; dge; dge; dge; dge; dge; dge; dge;	V 109	V 109 27G.0203 Privileging/Train Professionals 10A NCAC 27G.0203 Competen Qualified Professionals and Asso Professionals The Director of the Board of Direct (associate professional) is now be supervised by the qualified profess The QP and the President will wo to monitor the situation and assur does not occur again. Monitoring will take place monthly	cies of ciate ctors eing ssional. rk togeth e it	5/16/1

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Africe & Amite	President,	Board of Directors	5-20-18
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTA	TIVE'S SIGNATURE	TITLE	(X6) DATE

Division	of Health Service Regu	lation			FOr	RMAPPROV
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED
		MHL097-045	B. WING		05	/01/2018
AME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
			LY BROOK STREE			
IOLLY HI	LLS GROUP HOME		MILKESBORO, NC			
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C	ORRECTION	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	IE APPROPRIATE	COMPLE
V 109	Continued From page	1	V 109			
	(g) The associate pro supervised by a qualit population served for specified in Rule .010	ied professional with the the period of time as				
	failed to demonstrate the Professional staff /Exercise the Board of Directors	d record review, the facility that 1 of 1 Associate ecutive Director/President of received supervision from onal (QP) as required by with the QP revealed:				
	supervision to the AP/I Director/President of the	Executive				
2	Directors revealed: -Her career backgroun Veterinary Medicine; -She had been filling in	nd 5/1/18 with the President of the Board of d and education was in as the Program Director				
	-identifying and arran -meeting with facility and individually;	s were current; ssing the Medication (MARs) with facility staff; ging for staff training; staff monthly as a group				
-	-responding to any pr facility staff; She did not receive su She did not provide cli					

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Division of	of Health Service Regu	lation			FORI	MAPPROV
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:	CONSTRUCTION	(X3) DATE COMP	
		MHL097-045	B. WING		05/	01/2018
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STATE	E, ZIP CODE		
	LLS GROUP HOME	179 HOL	LY BROOK STREE	ET		
		NORTH V	VILKESBORO, NO	28659		
(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 CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLE DATE
V 109	Continued From page	2	V 109			
	staff.					
	staff (Staff #1) reveale -Supervisor note date staff #1 and AP/Execu- the Board of Directors discussion of MARs; -Supervisor note date staff #1 and AP/Execu- the Board of Directors and client progress no -Supervisor note date signed by staff #1 and Director/President of ti regarding discussion of Record review on 4/27 staff (Staff #2) reveale -Supervisor note dated staff #2 and AP/Execu- the Board of Directors discussion of MARs; -Supervisor note dated staff #2 and AP/Execu-	d 2/20/18 and signed by trive Director/President of regarding review and d 3/14/18 and signed by trive Director/President of regarding review of MARs tes; d 4/11/18 and signed by and AP/Executive he Board of Directors of client behavioral issue. d f client behavioral issue.				
	SUPERVISION OF PA (a) There shall be no p paraprofessionals.	COMPETENCIES AND RAPROFESSIONALS privileging requirements for shall be supervised by an	V 110			
		ed in Rule .0104 of this				

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE S COMPL	
		MHL097-045	B. WING		05/0	1/2018
	ROVIDER OR SUPPLIER	179 HOL	ADDRESS, CITY, ST LLY BROOK STI WILKESBORO,	REET		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLE DATE
V 110	<ul> <li>(c) Paraprofessiona knowledge, skills and population served.</li> <li>(d) At such time as a employment system then qualified profess professionals shall d (e) Competence sha exhibiting core skills</li> <li>(1) technical knowle</li> <li>(2) cultural awarene</li> <li>(3) analytical skills;</li> <li>(4) decision-making</li> <li>(5) interpersonal skii</li> <li>(6) communication s</li> <li>(7) clinical skills.</li> <li>(f) The governing bo develop and implement</li> </ul>	Is shall demonstrate d abilities required by the a competency-based is established by rulemaking, sionals and associate emonstrate competence. all be demonstrated by including: edge; ess; ; ; ; ; ; ; ; ; ; ; ; ; ; ; ; ;	V 110	V110 27G.0204 Training/Se Paraprofessionals 10A NCAC 27G.0204 Comp Supervision of Paraprofession Paraprofessional staff are no monthly supervision from a G Professional(QP). Records maintained of this supervision are filed in each paraprofess employee record. The President of the Board of will monitor to ensure that the occur again.	etencies and onals ow receiving Qualified are being on; records sional staff's	5/16/1
	failed to demonstrate (Staff #1 and #2) rece Qualified Professiona and agency policy. Th Interview with the QP -She performed client treatment plans; -She provided staff su goals were implement	nd record review, the facility 2 of 2 paraprofessional staff eived supervision from a I (QP) as required by rule ne findings are: on 4/27/18 revealed: assessments and wrote				

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:	ONSTRUCTION		E SURVEY PLETED
		MHL097-045	B. WING		05	/01/2018
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
	ILLS GROUP HOME	179 HOL	LY BROOK STREE	T		
		NORTH	WILKESBORO, NC	28659		
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPL DAT
V 110	Continued From page	e 4	V 110			
	-Her supervision cont her home; -She stated "I have be notes typed up and si -She stated "I'm sorry this." -She did not develop supervision plans with Review of the facility 4/27/18 revealed: The Supervision/Train statement, "The supe of supervision and tra Staff supervision and tra Staff supervision and tra group, observation). T by both the supervision Review of a staff super revealed: -Only one month (Apr and signed supervisio -No supervision by the Staff #2. Interview on 5/1/18 wi Professional/ Executiv Board of Directors rev -The QP had been tak	act notes were currently at een slack about getting my igned by staff"; . I should have already done or update individualized in staff. policy on supervision on hing Policy contained the rvisor will maintain a record ining for each staff member. training notes will be y basis and indicate the type ining provided (individual, "hese notes must be signed r and the supervisee." ervision record at the facility il 2018) of QP documented in notes on Staff #1; e QP was documented for th the Associate re Director/President of the				
V 118	supervision record. 27G .0209 (C) Medica	tion Requirements	V 118			
	10A NCAC 27G .0209 REQUIREMENTS (c) Medication adminis					

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Sector Sector States and Sector States	of Health Service Reg	ulation				MAPPROV
	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 × ×		(X3) DATE SURVEY COMPLETED	
		MHL097-045	B. WING		05/	01/2018
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
OLLY HI	LLS GROUP HOME	179 HOL	LY BROOK STR	REET		
		NORTH	WILKESBORO,	NC 28659		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT 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	(X5) COMPLET DATE
	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 administered current. Medications a recorded immediately MAR is to include the (A) client's name; (B) name, strength, ai (C) instructions for ad (D) date and time the (E) name or initials of drug. (5) Client requests for checks shall be record	In-prescription drugs shall to a client on the written horized by law to prescribe be self-administered by horized in writing by the ding injections, shall be licensed persons, or by rained by a registered nurse, egally qualified person and and administer medications. inistration Record (MAR) of d to each client must be kept administered shall be after administration. The following:	V 118	V 118 27G .0209 (C) Medication Requirements 10A NCAC 27G .0209 Medicatio Requirements MARs will be continuously monito by paraprofessional staff to ensu they are current. A staff meeting was held on 5/8/1 discuss the maintenance of MAR The President of the Board of Dir will monitor the MARs monthly to that they are current.	n ored re that 18 to s. rectors	5/16/18
	review, the facility faile	as evidenced by: bservation and record ed to ensure the MAR was nt #1) sampled clients. The				
	Review on 4/26/18 of Admission date: 9/12 h Service Regulation	Client #1's record revealed: /08				

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C	ONSTRUCTION		E SURVEY PLETED
			A. BUILDING:			
		MHL097-045	B. WING		05	/01/2018
AME OF PF	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
			LY BROOK STREE			
IOLLY HIL	LS GROUP HOME		WILKESBORO, NC			
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACT CROSS-REFERENCED TO		COMPLE DATE
			140	DEFICIENC		
V 118	Continued From page	6	V 118	······································		
	Diagnosos: Intolloctu	al Disability Disorder (IDD),				
	Mild, Darier Disease,					
	Disorder-Moderate, To					
		osacea, Allergic Rhinitis				
	-Client #1 had physica	· · · · · · · · · · · · · · · · · · ·				
	associated with Darier					
	-Client #1 had a docto	r's signed order dated				
		e (Atarax) hydrochloride				
		tablet by mouth at night for				
	30 days, then switch to					
		olet by mouth at night for 30				
	days.					
	Review on 4/26/18 of (	Client #1's Medication				
1		(MAR) from February 2018				
	through April 2018 rev					
		milligram, take 1-2 tablets				
	by mouth at bedtime a					
		actin), 4 mg, take 1 tablet				
	by mouth for 30 days a					
1	hydroxyzine HCL for ite	ching.				
1	Observation on 4/26/18	8 at 11:17 am of Client #1's				
	medication bottle label					
-	- hydroxyzine HCL, 10	mg, take 1 tablet by mouth				
	for 1 week for itching;					
		, take 1 tablet by mouth at				
	night for 1 week.					
1	Interview on 4/26/18 w	ith Staff #1 revealed:				
		ware the milligrams of the				
		different on the MAR from				
	the medication label;					
		the survey with the local				
		droxyzine HCL was filled				
		bed dosage of 10 mg with				
		et for 30 days and then				
	Client #1 was suppose	otadine, 4 mg for 30 days;				
	UNCHL # I WAS SUDDUSE					

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Division (	of Health Service Regu	llation			TORMAFFROM
	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C	CONSTRUCTION	(X3) DATE SURVEY
	UT CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING:		COMPLETED
			P. WANG		
		MHL097-045	B. WING		05/01/2018
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	E, ZIP CODE	
HOLLY HI	LLS GROUP HOME		LY BROOK STREE		
			VILKESBORO, NO	28659	
(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 COMPLETE
V 118	Continued From page	e 7	V 118		
	cyproheptadine (Peria	actin) for 30 days;			
	-She stated the MARs	s were copied over each			
	month;				
	-one needed to find ti	me to update the MARs.			
	Interview on 4/27/18	with the AP/Executive			
	Director/President of	the Board of Directors			~
	revealed:				
	discussing MARs with	es included reviewing and			
	-She had discussed th				
	accuracy with facility s				
	h Service Regulation				

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