Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: R B. WING MHL006006 06/04/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 198 CEMETARY ROAD **AVERY COUNTY GROUP HOME** NEWLAND, NC 28657 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE **PREFIX** (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) V 000 INITIAL COMMENTS V 000 An annual and follow up survey was completed on June 4, 2018. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities. **DHSR** - Mental Health V 109 27G .0203 Privileging/Training Professionals V 109 JUN 272018 10A NCAC 27G .0203 COMPETENCIES OF QUALIFIED PROFESSIONALS AND Lic. & Cert. Section ASSOCIATE PROFESSIONALS (a) There shall be no privileging requirements for qualified professionals or associate professionals. (b) Qualified professionals and associate professionals shall demonstrate knowledge, skills and abilities required by the population served. (c) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence. (d) 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. (e) Qualified professionals as specified in 10A NCAC 27G .0104 (18)(a) are deemed to have met the requirements of the competency-based employment system in the State Plan for MH/DD/SAS. (f) The governing body for each facility shall develop and implement policies and procedures for the initiation of an individualized supervision

Division of Health Service Regulation

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

plan upon hiring each associate professional.

(X6) DATE

STATE FORM

Residential Manager 6-18-18

PRINTED: 06/12/2018 FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: B. WING MHL006006 06/04/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 198 CEMETARY ROAD AVERY COUNTY GROUP HOME NEWLAND, NC 28657 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) V 109 | Continued From page 1 V 109 (g) The associate professional shall be supervised by a qualified professional with the population served for the period of time as specified in Rule .0104 of this Subchapter. This Rule is not met as evidenced by: Based on record review and interviews, facility staff failed to demonstrate knowledge, skills and abilities required by the population served for 1 of 3 audited staff (Staff #10). The findings are:

Division of Health Service Regulation

revealed:

#10 revealed:

Clients"

- Hire Date: 8/1/17

and supervision notes

MOVIE" with bad language and nudity

Review of Staff #10's employee file on 6/4/18

- Documentation of a current supervision plan

Review on 6/4/18 of a facility document titled, "Employee Warning Notice" dated 5/1/18 for Staff

-Type of Offenses: "Negligence of Group Home

-4/23/18: Residential Manager (RM) made aware

Staff #10 "slept all day Sunday" (4/22/18)

-Staff #10 reported had toothache

Network]" around 3AM on 4/22/18

had bad language and nudity

take clients to an "R rated movie"

-clients began preparing food unsupervised

-4/23/18: Staff #10 reported to be "on [Social

-4/29/18 (Sunday): Staff #10 contacted RM and reported taking clients to "a terrible movie" which

-RM had previously instructed Staff #10 not to

-4/30/18: clients reported going to a "VERY BAD

-after the movie a client requested to go get

Y5Z711

These 3 incidents 6/4/18

and staff # 10 6/4/18

were turned into Ins on June 1,2018

was made aware of

the fact that they

and a possibility of Investigation could happen. Staff 10 Knows if these

had been sent it

PRINTED: 06/12/2018 FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: R B. WING MHL006006 06/04/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 198 CEMETARY ROAD **AVERY COUNTY GROUP HOME** NEWLAND, NC 28657 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE **PREFIX** TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) V 109 Continued From page 2 V 109 6/4/18 food at a local restaurant near theater actions Continue -Staff #10 wanted to take her daughter home to happen She will first in another town -Staff #10 transported daughter in facility van -clients ate at restaurant in the other town and be fired. returned home late -clients received medications at 10PM rather than 8:30PM Rm, Q and Adrun will be more aware of Staff 10 work Interview on 6/4/18 with Client #1 revealed: -Once on a weekend, Staff #10 slept in a chair for about one hour: -Client #2 tried to wake the staff but was not successful: -Staff #10 took her daughter home after going to a movie and the clients had gotten their medications at 10PM. behausor Interview on 6/4/18 with Client #6 revealed: -A staff had slept once, but he woke her up. Interview on 6/4/18 with the RM revealed: -She had written Staff #10 a warning recently; -Staff #10 had slept on her shift during the daytime; -The clients had reported to her they had received their medications late another time; -She had instructed Staff #10 to stay at home when she was sick, to never take clients to R rated movies, make sure to administer

V 111 27G .0205 (A-B)

medications at the correct time, and not use the

This deficiency constitutes a recited deficiency and must be corrected within 30 days.

Assessment/Treatment/Habilitation Plan

facility van for personal use.

V 111

PRINTED: 06/12/2018 **FORM APPROVED** Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: R B. WING MHL006006 06/04/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 198 CEMETARY ROAD **AVERY COUNTY GROUP HOME** NEWLAND, NC 28657 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION **PREFIX** (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) V 111 Continued From page 3 V 111 10A NCAC 27G .0205 ASSESSMENT AND 111 6/4/18 A 1-5 + B TREATMENT/HABILITATION OR SERVICE PLAN have been Copied from the Day program (a) An assessment shall be completed for a client, according to governing body policy, prior to the delivery of services, and shall include, but not be limited to: (1) the client's presenting problem; file on Client 1+ 6 (2) the client's needs and strengths; (3) a provisional or admitting diagnosis with an and put into the Clients Group Home files - this was established diagnosis determined within 30 days of admission, except that a client admitted to a detoxification or other 24-hour medical program shall have an established diagnosis upon admission: (4) a pertinent social, family, and medical history; done with help of and (5) evaluations or assessments, such as psychiatric, substance abuse, medical, and vocational, as appropriate to the client's needs. (b) When services are provided prior to the establishment and implementation of the treatment/habilitation or service plan, hereafter referred to as the "plan," strategies to address the client's presenting problem shall be documented.

Division of Health Service Regulation STATE FORM

This Rule is not met as evidenced by:

Based on record review and interview, the facility failed to ensure completion of an assessment prior to service delivery which included presenting problem, needs, strengths, admitting diagnosis, pertinent social, family and medical history

Y57711

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		MHL006006	B. WING		R 06/04/2018
AVERY COUNTY GROUP HOME 198 CEM		198 CEME NEWLAND	DRESS, CITY, ST TARY ROAD O, NC 28657		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE
V 111	affecting 2 of 3 audite Client #5). The finding Review on 6/4/18 of C -Admission: 10/27/17 -Diagnoses: Mental R Functioning -Admission Assessme assessment was avail Review on 6/4/18 of C -Admission: 5/8/18 -Diagnoses: Mild to M Hyperlipidemia; Dysm -Admission Assessme assessment was avail Interview on 6/4/18 wit (PM) revealed: -She was unaware of a required an admission -Client #1 and Client # assessment; -The Qualified Profess an assessment for Clie to their attendance at t -The PM acknowledge	d clients (Client #1 and as are: Client #1's record revealed: etardation (MR) - High ent: No admission able Client #5's record revealed: oderate "Disabilities;" enorrhea nt: No admission able th the Program Manager a licensure rule which assessment for the clients; 5 had no admission ional (QP) had completed ent #1 and Client #5 related the Day Program;	V 111	admission ass were done or Chent 1+5. C put in front of their G. Home	sessments and 6/4/18 and 6/6/18 file
	individual admitted to to contain, but need not be	CLIENT RECORDS I be maintained for each the facility, which shall the limited to: the sheet which includes: the sheet which includes: the sheet which includes:	V 113	Identification Sheets were do or re-done on 6 chents and	all

DIVISION	of riealth Service Regu	lauon				
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE S	
		MHL006006	B. WING			R 0 4/2018
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, S1	ATE, ZIP CODE		
AVEDY CO	OUNTY GROUP HOME		TARY ROAD	,		
AVERTO	JONIT GROUP HOWLE	NEWLAND	, NC 28657			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	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 APPROPRI DEFICIENCY)	BE	(X5) COMPLETE DATE
V 113	Continued From page	5	V 113			6/4/18
	(C) date of birth;			in front of		6/6/18
	(D) race, gender and	marital status;		in front of each chents	01	10000
	(E) admission date;(F) discharge date;			each Chents	G. P	iome
	(2) documentation of r	mental illness,		file		
		ities or substance abuse		11.10		
	diagnosis coded accordance (3) documentation of t					
	assessment;	are corecting and				
	(4) treatment/habilitati					
		ation for each client which e, address and telephone				
		to be contacted in case of				
	sudden illness or accid	dent and the name, address				
	and telephone number physician;	r of the client's preferred				
		t from the client or legally				
	responsible person gra	anting permission to seek		T =		
	emergency care from a (7) documentation of s	a hospital or physician;		17,8		
		progress toward outcomes;		A B.C D		
	(9) if applicable:			Aloreid		1 1/ () C
	(A) documentation of p	hysical disorders International Classification		A,B,C,D Was also Copi	20	6/4/18
	of Diseases (ICD-9-CN			out of the Che	inds	
	(B) medication orders;			Did or	,	
	(C) orders and copies(D) documentation of r			day program to	1es	
		nd adverse drug reactions.		la datinto o	110	
	(b) Each facility shall e			day program fi and put into o G Home files.	<u></u>	
	only in accordance with	ted conditions is disclosed		G Home files.		
	disease laws as specifi					
	This Rule is not met as	s evidenced by:				
			1		1	

Based on record review and interviews, the

	CTTIOGRATIC CTVICE TREGO				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY
		I STATE OF THE MEDICAL	A. BUILDING	i:	COMPLETED
					R
		MHL006006	B. WING		06/04/2018
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE	
AVERYO	OUNTY OROUG HOME	198 CEM	ETARY ROAD		
AVERTO	OUNTY GROUP HOME	NEWLAN	D, NC 28657		
(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 CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE
	contact information, a granting permission to a hospital or physiciar (Clients #1 and Client Review on 6/4/18 of C -Admission: 10/27/17 -Diagnoses: Mental Re	ation face sheet, emergency and a signed statement be seek emergency care from a for 2 of 3 audited clients #5). The findings are:			
	-Emergency Information the facility which contains or physicians' names, numbers -Emergency Consent:	** *******			
	-Admission: 5/8/18 -Diagnoses: Mild to Mo Hyperlipidemia; Dysmo- Face Sheet: no face s -Emergency Information the facility which conta or physicians' names, a numbers -Emergency Consent:	enorrhea heet was in the record en: no record was kept in ined emergency contacts' addresses and phone			
	(PM) revealed: -She was unaware of a required an identificatio contact information and	on face sheet, emergency		Program Manac is very owere o what needs to be done from now	jer 6/18

(X3) DATE SURVEY

Division of Health Service Regulation

(X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: _ COMPLETED B. WING MHL006006 06/04/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 198 CEMETARY ROAD **AVERY COUNTY GROUP HOME** NEWLAND, NC 28657 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) V 113 | Continued From page 7 V 113 6/18 on when a new -Client #1 and Client #5 had no face sheet. emergency contact information and a signed Chent moves in statement granting permission to seek emergency care for each client: Q and Admin is also aware -The PM acknowledged understanding a face sheet, emergency contact information and a signed statement granting permission to seek emergency care was required by licensure rules. what needs to V 131 G.S. 131E-256 (D2) HCPR - Prior Employment V 131 Verification be done at G.S. §131E-256 HEALTH CARE PERSONNEL admiss 10 D REGISTRY (d2) Before hiring health care personnel into a health care facility or service, every employer at a health care facility shall access the Health Care Personnel Registry and shall note each incident of access in the appropriate business files. I talked with This Rule is not met as evidenced by: Admin and this Based on record review and interview, the facility failed to conduct an HCPR (Health Care Personnel Registry) check prior to the date of hire is in Policy and Procedures that no for 1 of 3 audited staff (Staff #10). The findings are: Review of Staff #10's employee file on 6/4/18 one is allowed to revealed: - Hire Date: 8/1/17 start working until - HCPR Check: 8/7/17 HCPR has cleared Interview on 6/4/18 with the Program Manager (PM) revealed:

(X2) MULTIPLE CONSTRUCTION

(X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES

AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE S	
			A. BOILDING.		R	
		MHL006006	B. WING			≺ 04/2018
NAME OF F	PROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, ST	TATE, ZIP CODE		
AVERY C	OUNTY GROUP HOME	198 CEMET	TARY ROAD			
NEWLAND		NEWLAND	, NC 28657			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETE DATE
V 131	Continued From page	8	V 131			
	-The Program Director check for Staff #1 had to the hire date.	r acknowledged the HCPR not been conducted prior utes a recited deficiency		Avery Association exceptioned Citiz requirements the application employment	for	
V 132	G.S. 131E-256(G) HC Allegations, & Protection		V 132	the application	OT	
	REGISTRY (g) Health care facilitie Department is notified health care personnel, unknown source, which any act listed in subdiv (which includes: a. Neglect or abuse of facility or a person to was defined by G.S. 131 as defined by G.S. 131 b. Misappropriation of in a health care facility, (b) of this section includers eservices as define hospice services as define hospice services as define hospice services as define hospice services as define hospice facility, d. Diversion of drugs to facility or to a patient or e. Fraud against a hea a patient or client for wh providing services). Facilities must have ev	of all allegations against including injuries of happear to be related to ision (a)(1) of this section. If a resident in a healthcare whom home care services E-136 or hospice services E-201 are being provided. If the property of a resident as defined in subsection ding places where home and by G.S. 131E-136 or fined by G.S. 131E-201 If the property of a resident as defined in subsection ding places where home and by G.S. 131E-201 If the property of a resident care relient. In alth care facility or against from the employee is ridence that all alleged and must make every effort in harm while the		emplogrition.		

(X2) MULTIPLE CONSTRUCTION

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

MHL006006

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

FORM APPROVIDER

(X3) DATE SURVEY COMPLETED

R

06/04/2018

NAME OF P	ROVIDER OR SUPPLIER STREET A	DDRESS, CITY, ST	TATE, ZIP CODE				
AVERY CO	OUNTY GROUP HOME 198 CEN	IETARY ROAD					
NEWLAND, NC 28657							
(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 132	Continued From page 9 investigations must be reported to the Department within five working days of the initial notification to the Department.	V 132					
	This Rule is not met as evidenced by: Based on record review and interview, the facility failed to assure all allegations of neglect were reported to the Health Care Personnel Registry (HCPR) within 24 hours of becoming aware of an allegation for 1 of 3 audited staff (Staff #10). The findings are:		All in cident were reported	6/4/18			
	Review of Staff #10's personnel file on 6/4/18 revealed: -Hire Date: 8/1/17 -Current Training: client rights, alternatives to restrictive interventions using an approved curriculum and treatment/behavioral plans		TO IRIS RM Las falked with Staff 10				
	Review on 6/4/18 of a facility document titled, "Employee Warning Notice" dated 5/1/18 for Staff #10 revealed: -Type of Offenses: "Negligence of Group Home Clients" -4/23/18: Residential Manager (RM) made aware Staff #10 "slept all day Sunday" (4/22/18) -clients began preparing food unsupervised -Staff #10 reported had toothache -4/23/18: Staff #10 reported to be "on [Social Network]" around 3AM on 4/22/18		about work performance and she knows next time is termination	le 141/1			

Ī							
l		T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY	
١		0. 001112011014	DENTIFICATION NUMBER.	A. BUILDING	:	COMPLETED	
l				1			
ŀ	MHL006006 B. WING			R 06/04/2018			
l	NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
l				TARY ROAD			
l	AVERY CO	DUNTY GROUP HOME		D, NC 28657			
r	(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	J (VE)	
l	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	(7.0)	TE
l	TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	NATE DATE	
H				+	DEFICIENCY)		
	V 132	Continued From page	10	V 132			
		-4/29/18 (Sunday): Sta	aff #10 contacted RM and				
			to "a terrible movie" which	1	2		
		had bad language and					
			nstructed Staff #10 not to	1			
		take clients to an "R ra					
	1		rted going to a "VERY BAD				
		MOVIE" with bad lang					
		-after the movie a cli	ent requested to go get				
		food at a local restaura					
			take her daughter home				
		first in another town					
			ed daughter in facility van				
			rant in the other town and				
		returned home late	E E				
		than 8:30PM	dications at 10PM rather	1			
		than 6.30PW				1	
		Interview on 6/4/18 wit	th Client #1 revealed:				
			Staff #10 slept in a chair for				
		about one hour;				-0	
		-Client #2 tried to wake	e the staff but was not		I MI Chents We	16	
		successful;			HIC COLO		
			ighter home and the clients		Included in a		
		had gotten their medical	ations at 10PM (late).		All chents we included in a house meeting	61511	8
					have meating	() ()	
	The state of the s	Interview on 6/4/18 wit			Rouse MEETING	311	- 1
		-A staff had slept once	, but he woke her up.		July S-18 and	were	
		Interview on 6/4/18 with	h the PM revealed:		2019	: 1	
			#10 an employee warning		made very aware	that	
		recently;	To all employee walfilling			1 - (-	
		-Staff #10 had slept on	her shift during the		all issues w/s	tato	
		daytime;	Jim dainig alo		are to he have	hat	
		-The clients had report	ed to her they had		are to be broug		
		received their medication			to RM attention		- 1
		-She had instructed Sta					
		when she was sick, to			things will get fir	ced	- 1
		rated movies, make sur	re to administer		' '		
		medications at the corn	ect time, and not use the				- 1

facility van for personal use;

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:	(X3) DATE SURVEY COMPLETED
	MHL006006	B. WING	R 06/04/2018
NAME OF PROVIDER OR SUPPLIER	STREET	DDRESS, CITY, STATE, ZIP CODE	
	198 CEM	IETARY POAD	

NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE					
AVERY C	OUNTY GROUP HOME	198 CEMET	ARY ROAD				
7472141 0	- TOWNE	NEWLAND,	NC 28657				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FI REGULATORY OR LSC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE		
V 132	Continued From page 11		V 132				
	-The RM was not aware she had to report S #10 to the HCPR within 24 hours after she had received the aforementioned allegations from clients; -She was unaware she was supposed to contain internal investigation of the reports.	nad m the nduct					
	27G .0604 Incident Reporting Requirements 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall report a level II incidents, except deaths, that occur d the provision of billable services or while the consumer is on the providers premises or level incidents and level II deaths involving the clie to whom the provider rendered any service w 90 days prior to the incident to the LME responsible for the catchment area where services are provided within 72 hours of becoming aware of the incident. The report s be submitted on a form provided by the Secretary. The report may be submitted via in person, facsimile or encrypted electronic means. The report shall include the following information: (1) reporting provider contact and identification information; (2) client identification information; (3) type of incident; (4) description of incident; (5) status of the effort to determine the cause of the incident; and (6) other individuals or authorities notifi or responding. (b) Category A and B providers shall explain missing or incomplete information. The provis shall submit an updated report to all required	all during vel III ents within shall mail, g	V 367				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 (1)	E CONSTRUCTION	(X3) DATE	
		A. BOILDING			_
	MHL006006	B. WING			R 04/2018
NAME OF PROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, ST	FATE, ZIP CODE		
AVERY COUNTY GROUP HOME	198 CEME	TARY ROAD			
AVERT COCKTT CROOF HOME	NEWLAND), NC 28657			
PREFIX (EACH DEFICIENCY	FEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETE DATE
day whenever: (1) the provider hinformation provided in erroneous, misleading (2) the provider or required on the incident unavailable. (c) Category A and B pupon request by the LN obtained regarding the (1) hospital recordinformation; (2) reports by oth (3) the provider's (d) Category A and B pupon fall level III incident results and the provider's (d) Category A and B pupon fall level III incident results and the providers shall send a concidents involving a click Health Service Regulating the client death within severor restraint, the provider immediately, as required. 300 and 10A NCAC 2 (e) Category A and B puport quarterly to the Loatchment area where so the client death within severor restraint and the provider immediately in the Loatchment area where so the category A and B puport quarterly to the Loatchment area where so the category of the secretary via eleginclude summary information of a level II or (2) restrictive integers the definition of a level II or (2) restrictive integers and the provider intege	as reason to believe that the report may be or otherwise unreliable; or obtains information at form that was previously providers shall submit, ME, other information incident, including: reds including confidential are authorities; and a response to the incident. Providers shall send a copy exports to the Division of omental Disabilities and incident. Category A copy of all level III ent death to the Division of incident. In cases of in days of use of seclusion or shall report the death d by 10A NCAC 26C PTE .0104(e)(18). Providers shall send a ME responsible for the services are provided. In a mitted on a form provided ctronic means and shall ination as follows: Forst that do not meet the level III incident; reventions that do not meet	V 367	DEFICIENCE		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			MHL006006	B. WING		1	R /04/2018
ľ	NAME OF B	ROVIDER OR SUPPLIER		DDF00 OID/ O	TATE TIP OCCU	1 00	104/2010
	NAME OF F	ROVIDER OR SUPPLIER		TARY ROAD	TATE, ZIP CODE		
	AVERY CO	DUNTY GROUP HOME	SECOND CONTRACTOR ACCORDS), NC 28657			
	(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 SHOULD CROSS-REFERENCED TO THE APPROPROFICIENCY)) BE	(X5) COMPLETE DATE
		the possession of a cli (5) the total numinoidents that occurred (6) a statement been no reportable indincidents have occurred meet any of the criteria (a) and (d) of this Rule through (4) of this Para This Rule is not met at Based on record reviet facility failed to report at Response Improvement Managed Care Organi hours of becoming away findings are: Review of Staff #10's prevealed: -Hire Date: 8/1/17 Review on 6/4/18 of a managed Care Organi Norgania Prevealed: -Type of Offenses: "New Clients" -4/23/18: Residential Mostaff #10 "slept all day clients began preparation of the component of t	client property or property in ient; inber of level II and level III d; and indicating that there have cidents whenever no ed during the quarter that a as set forth in Paragraphs and Subparagraphs (1) agraph. Is evidenced by: If a level II IRIS (Incident int System) incident to the zation (MCO) within 72 are of the incident. The incident incident incident incident incident incident incident. The incident incident incident incident incident. The incident incident incident incident incident incident. The incident incident incident incident incident incident incident. The incident incident. The incident incide	V 367			
		had bad language and	nudity				

Division of Health Service Regulation

				(X3) DATE SURVEY		
AND PLAN	PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING:		COMP	PLETED		
						_
		MUI noenne	B. WING	B WING		R
		MHL006006			06/	04/2018
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
		198 CEME	TARY ROAD			
AVERY C	DUNTY GROUP HOME		D, NC 28657			
(V4) ID	SLIMMADY ST		1	PROMPERS NAME OF THE		
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S		(X5) COMPLETE
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE A		DATE
				DEFICIENCY)		This the second
V 367	Continued From page	11	V 367			1
V 307	Continued From page	14	V 367			
	-RM had previously i	instructed Staff #10 not to	1			
	take clients to an "R ra	ated movie"				
	-4/30/18: clients repo	rted going to a "VERY BAD	İ			
	MOVIE" with bad lang					
		ient requested to go get				
	food at a local restaur					
	-Staff #10 wanted to	take her daughter home				
	first in another town	3				
	-Staff #10 transporte	ed daughter in facility van				
		rant in the other town and				
returned home late						
	-clients received medications at 10PM rather					
	than 8:30PM	and an in in in in in in				
	Interview on 6/4/18 wit	th Client #1 revealed:				
		Staff #10 slept in a chair for				
	about one hour:	oran no orope in a orian for				
	-Client #2 tried to wake	e the staff but was not				
	successful:	o the stall but was not				
		ughter home after going to				
	a movie and the clients					1
	medications at 10PM (
	modications at 101 m (idio).				
	Interview on 6/4/18 wit	th Client #6 revealed:				
	-A staff had slept once					
	7 Ctail Had Glopt Grido	, but no worke not up.				
	Interview on 6/4/18 wit	h the RM revealed:				
		#10 a warning recently;				
	-Staff #10 had slept on					
	daytime;	The shirt during the				
	-The clients had report	ed to the PM they had				
	received their medicati					1
		aff #10 to stay at home				
		never take clients to R				
3	rated movies, make su				ļ	
		rect time, and not use the				
	facility van for persona					ì
	-The RM was unaware					- 1
		d Staff #10 were Level II				
	incidents and required	an IRIS report, as well as,				- 1

Division of Health Service Regulation

DIVISION	or riealth Service Regu	lauon			
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		MHL006006	B. WING	····	R 06/04/2018
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE ZIP CODE	
			ETARY ROAD	7712, 211 3002	
AVERY CO	DUNTY GROUP HOME		D, NC 28657		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	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 367	Continued From page	15	V 367		
	a report to the MCO w	vithin 24 hours.			
V 736	27G .0303(c) Facility	and Grounds Maintenance	V 736		
	10A NCAC 27G .0303	LOCATION AND			
	EXTERIOR REQUIRE				
	(c) Each facility and its				
		clean, attractive and orderly			
	odor.	cept free from offensive			
	odor.			1	
	This Rule is not met a	is evidenced by:			
	Based on observations	s and interview, the facility			
		a clean, attractive, orderly			
		from offensive odors. The			
	findings are:				
	Observations on 5/31/	18 from 1:15PM thru			Chras
	3:30PM revealed the f			this black subst has been cleaned at base of shower	ances
		ne living room had a black		Cleaned	110 619118
		base of the shower and on		has been cleance	ωρ ωρ 1/10
	the tile;			at base of shower	and
		ove the base of the shower		on the tile -	
		had a black substance;			10
	-The handicapped bath			grouted areas, was	1.5
	the wall above the tile:	stance at the base and on		and tile have be	en
	- 11 시계 [편집 14명이 14명이 어린다면 하다 다시 그래요 [11 14명 14]	ad a window in their room;			
		had a black substance at		cleaned	ue 6/9/8
		and on the window seal;		no lo windows no	06 61718
		a black substance all over		I TILL OF A ME K	plack.
	the lower half of the bli			All 6 windows ho been cleaned of k	
	1 7 /4	se had wet carpet on the		substances.	1. 172/10
	floor in a 6 foot by 4 for which overflowed in fro			Substances. All blinds are co	ming willsills
	-The gutter appeared le			HIII O'	81(4519 810
		when entering the foyer;		down 6-23, 24-20	218 218

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED
		MHL006006	B. WING		R 06/04/2018
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 198 CEMETARY ROAD NEWLAND, NC 28657					
(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	
	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 16 -The wall in the foyer and to the left of the foyer door on the inside had a blackish substance; -The concrete sidewalk leading into the foyer door was cracked and uneven; -The concrete sidewalk was the area where clients exited the van and walked into the house; -Two grab bars on the sidewalk area where the clients exited and loaded the van were loose and unstable. Interview on 6/4/18 with the Residential Manager (RM) revealed: -The showers in the facility had been cleaned, but the black substance had remained on the tile; -The blinds in each client's room were almost new and were costly; -The wet carpet in the foyer had occurred because of the loose guttering; -Every time there was rain the carpet in the foyer was wet; -In the winter time, the rain would freeze as it flowed from the gutter and became long icicles; -At times when it rained or snowed, the clients had to cross the uneven sidewalk and enter or exit the facility from the staff's office door on the side of the house; -The carpet in the foyer had been there for two years and prior to that there was indoor/outdoor carpet which also became drenched during rain; -The gutter had leaked for at least five years; -She had reported the facility's physical problems to the homeowner on several occasions.		V 736	To be layed of on concrete and Spray with dil bleach water if it will clean of blinds - If will replace with curtains Foyer area is under contracts start working Gutters will be replaced and spar out in the from Concrete holes we be fixed tholes in foyer was will be fixed New door put in New Carpet in fall of these ite are being contracts.	to back not 6/18 to 6/18 ced to sell sold to sell ced
TATE FORM			5899 Y	1527 Put as of now	G-18-18 If continuation sheet 17 of 17