STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			B. WING		2010	
MHL068-135		B. WING		08/3	1/2018	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
DCI EDI		1508 EPH	ESUS CHUR	RCH ROAD		
KSI - EPI	HESUS CHURCH ROA	CHAPEL I	HILL, NC 27	517		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTI	ON	(X5)
PREFIX		MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL		COMPLETE DATE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO DEFICIENCY)	PRIAIE	DAIL
V 000	INITIAL COMMENT	TS .	V 000			
		as completed on August 31,				
	2018. Deficiencies	were cited.				
	This facility is linear	and for the following a comica				
		sed for the following service				
		C 27G .5600C Supervised h Developmental Disabilities.				
	Living for Addits wit	ii bevelopiiieiitai bisabiiities.				
\/ 100	27C 0202 (F.I) Dor	sonnel Requirements	V 108			
V 100	27G .0202 (F-I) Pel	sonnei Requirements	V 106			
	10A NCAC 27G .02	02 PERSONNEI				
	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;					
		nt rights and confidentiality as				
		CAC 27C, 27D, 27E, 27F and				
	10A NCAC 26B;	t the mh/dd/sa needs of the				
		the treatment/habilitation				
	plan; and	The deather demand				
	(4) training in infec	tious diseases and				
	bloodborne pathoge					
		itted under 10a NCAC 27G				
		chapter, at least one staff				
		vailable in the facility at all				
		is present. That staff				
		ained in basic first aid anagement, currently trained				
	to provide cardiopulmonary resuscitation and trained in the Heimlich maneuver or other first aid					
		those provided by Red Cross,				
		Association or their				
		eving airway obstruction.				
		ody shall develop and				
		and procedures for identifying,				
		ting and controlling infectious				
	and communicable	diseases of personnel and				

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

(X6) DATE TITLE

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(3) DATE SURVEY COMPLETED	
MHL068-135		B. WING 08		08/3	08/31/2018		
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
RSI - EP	HESUS CHURCH RO	ΔΙ)	ESUS CHUR HILL, NC 27				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES			PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
V 108	clients.		V 108				
	This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to have documentation of current Cardiopulmonary Resuscitation and First Aid training for one of three audited staff (the Supervisor of Support Services/Qualified Professional). The findings are:						
	Review of personnel records on 8/31/18 revealed: -The Supervisor of Support Services/Qualified Professional had a hire date of 8/7/12The Supervisor of Support Services/Qualified Professional's Cardiopulmonary Resuscitation and First Aid training had expired 7/19/18There was no documentation of a current First Aid and Cardiopulmonary Resuscitation training for the Supervisor of Support Services/Qualified Professional.						
	Support Services/G-She had just return maternity leaveShe confirmed that Cardiopulmonary RexpiredShe acknowledged clients at the home-She was schedule Cardiopulmonary Responsible 19/15/18.	Resuscitation training had d that she had been alone with d to complete First Aid and Resuscitation training on					
	Interview with the E revealed:	Director of Autism Services					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) A. BUILDING:			X3) DATE SURVEY COMPLETED	
		MHL068-135	B. WING		08/3	31/2018
RSI - EPHESUS CHURCH ROAD 1508 EPHE			DDRESS, CITY, SHESUS CHUR			
(X4) ID PREFIX TAG	(EACH DEFICIENCY		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
V 108	REGULATORY OR LSC IDENTIFYING INFORMATION)		V 108			
V 118	10A NCAC 27G .02 REQUIREMENTS (c) Medication adm (1) Prescription or r only be administere order of a person a drugs. (2) Medications sha clients only when a client's physician.		V 118			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		MHL068-135	B. WING		08/3	31/2018
	PROVIDER OR SUPPLIER	1508 EPH	ESUS CHUR			
			HILL, NC 27			T.
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
V 118	unlicensed persons pharmacist or other privileged to prepar (4) A Medication Ad all drugs administer current. Medication recorded immediate MAR is to include the (A) client's name; (B) name, strength, (C) instructions for (D) date and time the (E) name or initials drug. (5) Client requests checks shall be recorded.	by licensed persons, or by a trained by a registered nurse, legally qualified person and e and administer medications. Iministration Record (MAR) of red to each client must be kept administered shall be ely after administration. The	V 118			
	facility failed to ensi affecting one of thre findings are: Review on 8/31/18 -Admission date of -Diagnoses of Mod- Histrionic Personali Action Type Tremon	views and interviews the ure the MAR was kept current ee audited clients (#2). The of Client #2's record revealed: 5/14/07. erate Mental Retardation, ty Disorder, Obesity and control of Client #2's physician orders				
-Listerine- Use 1 ml twice dailyLoratadine 10mg- Take one tablet every day.						

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
MHL068-135		B. WING		08/31/2018		
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
RSI - EPI	HESUS CHURCH ROA	AD .	ESUS CHUR			
		CHAPEL I	HILL, NC 27			
(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 APPROINT DEFICIENCY)	D BE	(X5) COMPLETE DATE
V 118	Continued From pa	ge 4	V 118			
V 118	-Fluticasone Propio sprays in each nost - Preplus 27-1 mg-Primidone 50 mg-bedtime for tremors - Risperidone .5 mg - Divalproex 500 mg at bedtimePropranolol- Take - Selenium Sulfide 1 shampoo hair daily. Review on 8/31/18 2018 through Augu following dates: -Listerine- 6/1/18 - 8/31/18Loratadine 10mg-7/31/18, 8/1/18- 8/3-Fluticasone Propio 7/11/18 - 7/31/18, 8/1/18- 8/3-Primidone 50 mg-7/31/18, 8/1/18- 8/3-Primidone 50 mg-7/31/18, 8/1/18- 8/3-Divalproex 500 mg-7/31/18, 8/1/18- 8/3-Propranolol- 6/1/1 8/1/18- 8/31/18Selenium Sulfide 1 6/30/18, 7/1/18 - 7/3-She had been resi	onate 50 mcg- Inhale two tril every day. Take one tablet every day. Take four tablets (200 mg) at s Take one tablet at bedtime. g- Take two tablets (1000 mg) one tablet twice a day. 1% suspension- Use 5 ml to of Client #2's MAR for June st 2018 revealed blanks on the st 2018 revealed blanks on the 6/30/18, 7/1/18 - 6/30/18, 1/18- 8/31/18. onate 50 mcg- 6/1/18 - 6/30/18, 1/18- 8/31/18. 6/1/18 - 6/30/18, 7/1/18 - 8/31/18. 6/1/18 - 6/30/18, 7/1/18 - 8/31/18. 6/1/18 - 6/30/18, 7/1/18 - 8/31/18. 6/1/18 - 6/30/18, 7/1/18 - 8/31/18. 6/1/18 - 6/30/18, 7/1/18 - 8/31/18. 6/1/18 - 6/30/18, 7/1/18 - 8/31/18.	V 118			
	yearsShe liked staff and other residents at the homeShe had never had any trouble getting her					

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medications.

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
MHL068-135		B. WING		08/31/2018		
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
RSI - EP	HESUS CHURCH ROA	AD .	ESUS CHUR HILL, NC 27			
(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 118	-She administered -She locked her me Interview with the S Services/Qualified revealed: -Client #2 had a ph could self-administe -Client #2 had beer medications since of the services and the services and the services confirmed the services confirmed -The facility failed to current for Client #2 -MAR is reviewed for the services and the services are services and the services and the services and the services are services and the services and the services and the services are services and the services	her own medications. Edications in her bedroom. Supervisor of Support Professional on 8/31/18 ysician note indicating that she er medications. In self administering her January. I Client #2 if she had taken her book her medications as I August 2018 MAR's were left because staff thought they did the it since she was self medications. Only assisted Client #2 with her facility failed to ensure the ent for Client #2. 8 with the Director of Autism content of the month of the beginning of the month	V 118			

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