STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			B. WING		R	
		MHL013-153			09/	19/2018
IAME OF PR	OVIDER OR SUPPLIER		ADDRESS, CITY, STATE	, ZIP CODE		
SHLYNN	GROUP HOME		LYNN DRIVE RD, NC 28025			
(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 ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLET DATE
V 000	INITIAL COMMENTS	3	V 000			
		and follow up survey was 3. Deficiencies were cited.				
		d for the following service 27G .5600A Supervised Mental Illness.				
V 112	27G .0205 (C-D) Assessment/Treatme	nt/Habilitation Plan	V 112			
	PLAN (c) The plan shall be assessment, and in p legally responsible pe of admission for clien receive services beyo (d) The plan shall ind (1) client outcome(s achieved by provision projected date of ach (2) strategies; (3) staff responsible (4) a schedule for re annually in consultati responsible person o (5) basis for evaluat outcome achievemen (6) written consent of responsible party, or	TATION OR SERVICE developed based on the partnership with the client or erson or both, within 30 days its who are expected to ond 30 days. clude:) that are anticipated to be n of the service and a ievement; ; eview of the plan at least on with the client or legally r both; ion or assessment of				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			
		MHL013-153	B. WING		09	R / 19/2018
IAME OF PR	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE		
SHLYNN	GROUP HOME		LYNN DRIVE RD, NC 28025			
	SUMMARY ST		ID	PROVIDER'S PLAN O	E CORRECTION	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE	(X5) COMPLET DATE
V 112	Continued From pag	e 1	V 112			
	This Rule is not met	-				
	interviews, the facility	view. observation and y failed to develop and to address client needs				
		nt clients (#1) and 1 of 1				
	-admission date of 1/	client #1's record revealed: /13/15 with diagnosis of				
	Schizophrenia, Irritable Bowel Syndrome, Alcohol Dependence in Full Remission and Hypercholesterolemia;					
	following goals: repo	d 6/25/18 documented the rt medical concerns as e appropriate social skills				
		mental health stability and				
	-admission date of 5/	FC#3's record revealed: /25/17 with diagnosis of				
	Schizophrenia, Anxie Pulmonary Disease a -discharged on 9/8/1					
	-treatment plan dated following goals: work	5/29/18 documented the on independent living skills,				
		use unsupervised time all appointments and take all ns.				
	Review on 9/4/18 of from 5/1/18-9/4/18 re	the facility incident reports evealed the following:				
	-7/28/18 client #1 ad	mitted to checking his ng to FC#3, was not able to				
	-7/28/18 client #1 bro cabinet and took a te	oke into the locked storage levision and gave it to a				
	peer; -7/30/18 it was repor					

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED
			A. BUILDING:			
		MHL013-153	B. WING		R 09/19/2018	
NAME OF PI	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE		
SHLYNN	GROUP HOME		LYNN DRIVE RD, NC 28025			
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 112	Continued From page	e 2	V 112			
	medications from client #1, crushing them and snorting them, FC#3 denied it.					
	-gave FC#3 his Well	tions and gave to FC#3; times; ettes;				
	him(FC#3) medicatio	he(client #1) was giving on;				
	Observation 12:20pn medications on site r -bupropion (generic f tablet daily;	n on 9/4/18 of client #1's evealed: for Wellbutrin) 150mg one for Ativan) 0.5mg one tablet				
	medications prior to r -staff administer med -once information car	d; ny clients trying to cheek report made by client #1; lications to clients; me out, staff began to do ok inside clients' mouths to				
	revealed: -no history of cheekir -no updated strategie addressing the issue	4/18 of client #1's record ng medications; es in the treatment plan of cheeking medications; es in the treatment plan for				

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f Health Service Regu OF DEFICIENCIES F CORRECTION			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		SURVEY
	MHL013-153	B. WING		R / 19/2018	
ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
GROUP HOME					
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
Continued From page	e 3	V 112			
taking property that d	oes not belong to him.				
revealed: -no history of cheekin other clients' medicat -no updated strategie	ng medications or taking ions; s in the treatment plan				
27G .5602 Supervise	d Living - Staff	V 290			
 (a) Staff-client ratios numbers specified in of this Rule shall be of enable staff to respon- needs. (b) A minimum of one present at all times we premises, except whe habilitation plan docu capable of remaining without supervision. as needed but not less the client continues to the home or commun specified periods of ti (c) Staff shall be prese following client-staff r child or adolescent cl (1) children or a abuse disorders shall 	above the minimum Paragraphs (b), (c) and (d) determined by the facility to nd to individualized client e staff member shall be then any adult client is on the en the client's treatment or ments that the client is in the home or community The plan shall be reviewed as than annually to ensure to be capable of remaining in hity without supervision for me. sent in a facility in the ratios when more than one ient is present: adolescents with substance I be served with a minimum				
	ROVIDER OR SUPPLIER GROUP HOME SUMMARY ST (EACH DEFICIENC REGULATORY OR Continued From page taking property that d Further review on 9/4 revealed: -no history of cheekir other clients' medicat -no updated strategie addressing the issue medications. This deficiency const and must be correcte 27G .5602 Supervise 10A NCAC 27G .5602 (a) Staff-client ratios numbers specified in of this Rule shall be corrected 10A NCAC 27G .5602 (b) A minimum of on- present at all times w premises, except whe habilitation plan docu capable of remaining without supervision. as needed but not less the client continues to the home or commun specified periods of ti (c) Staff shall be pre- following client-staff r child or adolescent cl (1) children or abuse disorders shall of one staff present for	F CORRECTION IDENTIFICATION NUMBER: IDENTIFICATION NUMBER: MHL013-153 ROVIDER OR SUPPLIER STREET A GROUP HOME SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 3 taking property that does not belong to him. Further review on 9/4/18 of FC#3's record revealed:	F CORRECTION IDENTIFICATION NUMBER: A. BUILDING: MHL013-153 B. WING COVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE SUMMARY STATEMENT OF DEFICIENCIES B. SUMMARY STATEMENT OF DEFICIENCIES ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG Continued From page 3 V 112 taking property that does not belong to him. Further review on 9/4/18 of FC#3's record revealed: V 112 -no history of cheeking medications or taking other clients' medications; -no updated strategies in the treatment plan addressing the issue with taking other clients' medications. V 290 This deficiency constitutes a re-cited deficiency and must be corrected within 30 days. V 290 27G .5602 Supervised Living - Staff V 290 10A NCAC 27G .5602 STAFF (a) Staff-client ratios above the minimum numbers specified in Paragraphs (b), (c) and (d) of this Rule shall be determined by the facility to enable staff to respond to individualized client needs. V 290 (b) A minimum of one staff member shall be present at all times when any adult client is on the premises, except when the client's treatment or habilitation plan documents that the client is capable of remaining in the home or community without supervision. The plan shall be reviewed as needed but not less than annually to ensure the client continues to be capable of remaining in the home or community without supervision for spe	F CORRECTION IDENTIFICATION NUMBER: A. BUILDING: MHL013-153 B. WING GROUP HOME STREET ADDRESS, CITY, STATE, ZIP CODE GROUP HOME S9 ASHLYNN DRIVE CONCORD, NC 28025 SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE AC (EACH CORRECTIVE AC COROSS-REFERENCED TO DEFICIENCY WINTS BE PRECEDED BO Y PULL REGULATORY OR LSC IDENTIFYING INFORMATION) 10 PREVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN Continued From page 3 V 112 Continued From page 3 taking property that does not belong to him. V 112 Further review on 9/4/18 of FC#3's record revealed: -no updated strategies in the treatment plan addressing the issue with taking other clients' medications. V 112 This deficiency constitutes a re-cited deficiency and must be corrected within 30 days. V 290 10A NCAC 27G .5602 STAFF (a) Staff-client ratios above the minimum numbers specified in Paragraphs (b), (c) and (d) of this Rule shall be determined by the facility to enable staff to respond to individualized client needs. V 290 (b) A minimum of one staff member shall be present at all times when any adult client is on the premises, except when the client's to capable of remaining in the home or community without supervision. The plan shall be reviewed as needed but not less than annually to ensure the client continues to be capable of remaining in the home or community without supervision for specified periods of time. (c) Staff shall be present in a facility in the following client-staff ratios when	F CORRECTION IDENTIFICATION NUMBER: A BUILDING:

Division of Health Service Regulation STATE FORM

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STATEMENT	of Health Service Regu OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
		MHL013-153	B. WING		09	R / 19/2018
NAME OF PI	ROVIDER OR SUPPLIER	STREET	DDRESS, CITY, STATE	, ZIP CODE		
SHLYNN	GROUP HOME		YNN DRIVE RD, NC 28025			
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 290	Continued From page	e 4	V 290			
	the governing body; of (2) children or developmental disability one staff present for present and two staff more clients present. need be present duri specified by the eme determined by the go (d) In facilities which diagnosis is substant (1) at least one duty shall be trained withdrawal symptoms secondary complication drug addiction; and	adolescents with ilities shall be served with every one to three clients f present for every four or . However, only one staff ng sleeping hours if rgency back-up procedures overning body. a serve clients whose primary ce abuse dependency: e staff member who is on in alcohol and other drug s and symptoms of ions to alcohol and other s of a certified substance Il be available on an				
	facility failed to ensure member was present client is on the premi- treatment or habilitation client is capable of re- community without sureviewed as needed continues to be capa or community without periods of time affect	view and interviews, the re a minimum of one staff t at all times when any adult ses, except when the client's ion plan documents that the emaining in the home or upervision and the plan was				
		client #1's record revealed: /13/15 with diagnosis of				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C		(X3) DATE SURVEY COMPLETED R 09/19/2018	
		BENTH IOATION NOMBER.	A. BUILDING:			
		MHL013-153				
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
ASHLYNN	GROUP HOME		YNN DRIVE			
		CONCO	RD, NC 28025			
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENT	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 290	Continued From pag	e 5	V 290			
	Schizophrenia, Irritable Bowel Syndrome, Alcohol Dependence in Full Remission and Hypercholesterolemia; -treatment plan dated 6/25/18 documented the ability to have supervised time in the community and in the facility. Review on 9/4/18 of FC#3's record revealed: -admission date of 5/25/17 with diagnosis of Schizophrenia, Anxiety, Chronic Obstructive					
	Pulmonary Disease a -discharge date of 9/ -treatment plan dated following goal: use u successfully.	8/18; d 5/29/18 documented the				
	from 5/1/18-9/4/18 re -7/28/18 client 12 ad medications and givi give dates or times; -7/28/18 client #1 bro	the facility incident reports evealed the following: mitted to checking his ng to FC#3, was not able to oke into the locked storage elevision and gave it to a				
	-7/30/18 it was repor medications from clie snorting them, FC#3 -7/30/18 client #1 alle	ent #1, crushing them and denied it; eged FC#3 sexually ven), FC#3 became unstable				
	records revealed no assessments presen the continued capabi	4/18 of client #1's and FC#3's updated unsupervised time t in the record to determine ility to have unsupervised he incidents listed above.				
	Interview on 9/4/18 v Professional reveale -once sexual allegati alth Service Regulation					

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of Health Service Regu OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
				R		
	MHL013-153	B. WING		09	9/19/2018	
ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	, ZIP CODE			
GROUP HOME						
(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE A CROSS-REFERENCED TO	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLET DATE	
Continued From pag	e 6	V 290				
place, a safety plan y -FC#3 left the facility member two days aff few days and then le -no updated unsuper completed on client # above listed incident -did provide extra sta for FC#3 due to the r	was implemented; to go stay with a family ter allegations, returned for a off again, did not return; rvised assessments were #1 and FC#3 in response to s; affing and one on one staffing nature of the allegations and					
	Continued From pag awake staffing and b place, a safety plan -FC#3 left the facility member two days af few days and then le -no updated unsuper completed on client above listed incident -did provide extra sta for FC#3 due to the facility	OF CORRECTION IDENTIFICATION NUMBER: MHL013-153 ROVIDER OR SUPPLIER STREET A BROUP HOME 89 ASHI	DF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: MHL013-153 B. WING ROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE GROUP HOME 89 ASHLYNN DRIVE CONCORD, NC 28025 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG Continued From page 6 V 290 awake staffing and bed checks were put into place, a safety plan was implemented; -FC#3 left the facility to go stay with a family member two days after allegations, returned for a few days and then left again, did not return; -no updated unsupervised assessments were completed on client #1 and FC#3 in response to above listed incidents; -did provide extra staffing and one on one staffing for FC#3 due to the nature of the allegations and V	DF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: MHL013-153 B. WING ROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE GROUP HOME 89 ASHLYNN DRIVE CONCORD, NC 28025 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN O (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE Continued From page 6 V 290 V 290 V 290 awake staffing and bed checks were put into place, a safety plan was implemented; FC#3 left the facility to go stay with a family member two days after allegations, returned for a few days and then left again, did not return; -no updated unsupervised assessments were completed on client #1 and FC#3 in response to above listed incidents; -did provide extra staffing and one on one staffing for FC#3 due to the nature of the allegations and III D	DF CORRECTION IDENTIFICATION NUMBER: A. BUILDING:	