		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED R	
	MHL092-795		B. WING		10/22/2018	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	, ZIP CODE		
IFE SKIL	LS INDEPENDENT CAR	E #1	RY HOWARD ROA			
	-	FUQUAY	YVARINA, NC 2752	26		
(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 CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	TION SHOULD BE COM THE APPROPRIATE E	
V 000	INITIAL COMMENTS		V 000			
	was completed Octol limited follow up surv 27G.1701 Residentia including any cross r (V112) and 10A NCA Protection from Negl for compliance. The into compliance. The into compliance into Residential Treatmen any cross referenced NCAC 27D.0304 Clie Neglect (V512) . A de This facility is license	al Treatment Children (V293) eferenced deficiencies C 27D.0304 Client Rights- ect (V512) were reviewed following were brought back NCAC 27G.1701 ht Children (V293) including d deficiencies (V112) and 10A ent Rights- Protection from eficieincy was recited. ed for the following service 5 27G .1700 Residential				
V 108	 (g) Employee trainin provided and, at a m following: (1) general organization (2) training on client delineated in 10A NC 10A NCAC 26B; (3) training to meet client as specified in plan; and (4) training in infection bloodborne pathoger (h) Except as permittit .5602(b) of this Subor 	2 PERSONNEL tion shall be documented. g programs shall be inimum, shall consist of the ational orientation; t rights and confidentiality as CAC 27C, 27D, 27E, 27F and the mh/dd/sa needs of the the treatment/habilitation	V 108			

Division of Health Service Regulation STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL092-795		(X2) MULTIPLE C		(X3) DATE SURVEY COMPLETED			
		IDENTIFICATION NOWBEN.	A. BUILDING:				
		B. WING	10	R 10/22/2018			
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE			
		800 PER	RY HOWARD ROA	D			
	LS INDEPENDENT CAR	FUQUAY	VARINA, NC 2752	26			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN O		(,,,)		
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO		COMPLET DATE	
				DEFICIEN	CY)		
V 108	Continued From page	e 1	V 108				
	times when a client is present. That staff						
	member shall be train						
		nagement, currently trained					
	to provide cardiopulmonary resuscitation and						
	trained in the Heimlich maneuver or other first aid						
	techniques such as those provided by Red Cross,						
	the American Heart Association or their						
	equivalence for relieving airway obstruction.						
	(i) The governing body shall develop and						
	implement policies and procedures for identifying,						
	reporting, investigatir	ng and controlling infectious					
	and communicable d	iseases of personnel and					
	clients.						
	This Rule is not met	as evidenced by:					
	Based on observation and interviews, the facility						
	failed to assure two of two audited staff (#1 and						
		were provided education					
		on of the facility's alarm					
	system. The findings	are:					
	Observation and tour	of the facility on 10/15/18					
	between 3:30-5:30 P	-					
	-Two staff (Hous	e Manager and staff #1) at					
	the facility with one c						
	-Staff #1 activated alarm by opening window						
	in client #1's bedroom. Once the alarm engaged,						
		to disengage the alarm					
	using the control pan						
		he alarm company was					
	heard via an intercon	n system in which					
		code information was					
	requested from staff.	Staff #1 provided incorrect					
	information. The Hou	se Manager provided the					
	correct code. Alarm	was disengaged by the alarm					
	company.						

Division of Health Service Regulation STATE FORM

EKG711

Division of Health Service Regulation STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL092-795			(X2) MULTIPLE CO A. BUILDING:		(X3) DATE SURVEY COMPLETED R 10/22/2018	
		MHL092-795	B. WING	10		
IAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
		800 PER		D		
IFE SKIL	LS INDEPENDENT CAR	E #1 FUQUAY	VARINA, NC 2752	26		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN O		· · ·	
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	THE APPROPRIATE	COMPLET DATE
V 108	Continued From page	e 2	V 108			
	During interview on 10/15/18, staff #1 reported					
	she: -Normally worked at another group home managed by the same licensee.					
	-Would not have to engaged or disengaged the alarm system as she worked during the day					
	time hours	ained on how to operate the				
	-Had not been trained on how to operate the alarm system inclusive of how to engage and					
	•	n at the control panel in the				
	reported she:	0/15/18, the House Manager				
	disengage the alarm	assist staff #1 to engage or at the facility. When she left shift, she did not engage or				
	used a key to lock the	sing the control panel, she e door of the facility. Irm was engaged and				
		by the Residential Support				
	During interview on 1 reported:	0/10/18, the Licensee				
	at the facilitythe sta Support Specialist er	age and disengage the alarm If and the Residential Igaged and disengaged the				
	facility's alarmthe s disengaged the alarn control panel and the	n in the facility using the				
	Specialist engaged as well as disengaged the facility's alarm remotely on his cell phone.					
	-The staff at the trained by the alarm	group home had been company.				
	This deficiency const and must be correcte	itutes a re-cited deficiency				