Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION (X3) A. BUILDING:			
MHL092-299			B. WING	B. WING		
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	E. ZIP CODE	•	/13/2018
			RKS VILLAGE RO			
WILKINS	HOME	ZEBULO	ON, NC 27597			
(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 COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
V 000	INITIAL COMMENTS		V 000			
	on November 13, 201 This facility is license category: 10A NCAC	-up survey was completed 8. Deficiencies were cited. d for the following service 27G. 5600F Supervised Developmental Disabilities.				
V 112	V 112 27G .0205 (C-D) Assessment/Treatment/Habilitation Plan		V 112			
	10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (c) The plan shall be developed based on the assessment, and in partnership with the client or legally responsible person or both, within 30 days of admission for clients who are expected to receive services beyond 30 days. (d) The plan shall include: (1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement; (2) strategies; (3) staff responsible; (4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both; (5) basis for evaluation or assessment of outcome achievement; and (6) written consent or agreement by the client or responsible party, or a written statement by the provider stating why such consent could not be obtained.					

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED			
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MHL092-299 B. WI			B. WING		11/1:	11/13/2018	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE			
WILKINS	HOME	1517 PAR	S VILLAGE R	OAD			
WILKING		ZEBULON	NC 27597			,	
(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 112	2 Continued From page 1		V 112				
	This Rule is not met as evidenced by: Based on record review and interview, the facility failed to maintain a treatment plan annually for 2 of 2 clients (#1 and #2). The findings are:						
Review on 11/9/18 of client #1's record revealed: - admission date 2/21/02 - diagnoses of Intellectual and Developmental Disabilities, Diabetes, Hypertension, Non-Hodgkin's Lymphoma, Hyperlipidemia and							
	Osteoporosis - an assessment dated 8/1/18 identifying client #1's needs as learning to read and write, completing tasks and increasing her daily living skills						
	- no treatment plan in the record						
	- admission date - diagnoses of M Developmental Disab Seizure Disorder, Dys Esophageal Reflux D Hyperlipidemia, Chro Tachycardia, Cerebra Status/Post left Hip R - an assessment client #2's needs as re	ild Intellectual and ilities, Bipolar Disorder, sthymic Disorder, Gastro isease, Leukopenia, nic kidney Disease, il Osteoarthritis and					
	restlessness - no treatment pla	-					
During an interview on 11/9/18, the provider/owner reported: - client #1's goals included: slowing down her eating and cutting up food into small bites; decrease pacing; assisting in choosing her own clothes; assisting with chores; assisting with purchases and slowing down her speech							

Division of Health Service Regulation

STATE FORM 6899 7B4F11 If continuation sheet 2 of 6

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	(X3) DATE SURVEY COMPLETED			
		D WING				
		MHL092-299	B. WING		11/13/2018	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE		
WILKINS	НОМЕ		KS VILLAGE R	OAD		
	QUII II I I I I I I I I I I I I I I I I		N, NC 27597			
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V 112	Continued From page	2	V 112			
	- client #2's goals included: decreasing isolation and increasing socialization and maintaining all adult daily living skills - she used to always keep treatment plans and do progress notes but stopped last year at the suggestion of the Qualified Professional During an interview on 11/9/18, the Qualified Professional reported: - they previously had goals for the clients but as they got older and most of their needs were related to personal care they stopped writing out the goals since the clients were not "Innovations" clients, he did not think a plan was necessary - they also did not document the services they provided daily or document progress towards outcomes - they would immediately go back to having treatment plans and progress notes					
	sheet submitted by th 11/13/18 for clients #1 goals and intervention listed above. These	f "goals and strategies" e Qualified Professional on I and #2 revealed specific ns related to the issues goals and strategies were alified Professional after eyor on 11/9/18				
V 113	27G .0206 Client Rec	ords	V 113			
	individual admitted to contain, but need not	all be maintained for each the facility, which shall be limited to: ce sheet which includes: niddle, maiden);				

Division of Health Service Regulation

STATE FORM 6899 7B4F11 If continuation sheet 3 of 6

Division of Health Service Regulation

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE ### STATE ADDRESS, CITY, STATE, ZIP	. ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER WIKINS HOME CALL DESCRIPTION SUMMARY STATEMENT OF DEFICIENCIES DESCRIPTION PREFIX TAG TAG DEFICIENCY MUST BE PRECEDED BY FULL TAG DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG TAG DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG DEFICIENCY DEFICIE	MHL092-299		B. WING		11/13/2018			
XALID SUMMARY STATEMENT OF DEFICIENCIES PRECINC REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDERS PLAN OF CORRECTION (EACH OPERICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) PRECINC TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PRECINC TAG CONSS.REFERENCED TO THE APPROPRIATE DATE V 113 Continued From page 3 V 113 (D) race, gender and marital status; (E) admission date; (F) discharge date; (2) documentation of mental illness, developmental disabilities or substance abuse diagnosis coded according to DSM IV; (3) documentation of the screening and assessment; (4) treatment/habilitation or service plan; (5) emergency information for each client which shall include the name, address and telephone number of the person to be contacted in case of sudden illness or accident and the name, address and telephone number of the client's preferred physician; (6) a signed statement from the client or legally responsible person granting permission to seek emergency care from a hospital or physician; (7) documentation of progress toward outcomes; (9) if applicable: (A) documentation of progress toward outcomes; (9) if applicable: (A) documentation of physical disorders diagnosis according to International Classification of Diseases (ICD-9-CM); (B) medication orders; (C) orders and copies of lab tests; and (D) documentation of medication and administration errors and adverse drug reactions. (b) Each facility shall ensure that information relative to AIDS or related conditions is disclosed only in accordance with the communicable	NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	•		
(A) ID SUMMARY STATEMENT OF DEFICIENCIES DE PROVIDERS PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) V 113 Continued From page 3 (D) race, gender and marital status; (E) admission date; (F) discharge date; (2) documentation of mental illness, developmental disabilities or substance abuse diagnosis coded according to DSM IV; (3) documentation of the screening and assessment; (4) treatment/habilitation or service plan; (5) emergency information for each client which shall include the name, address and telephone number of the person to be contacted in case of sudden illness or accident and the name, address and telephone number of the person to be contacted in case of sudden illness or accident and the name, address and telephone number of the person spital or physician; (6) a signed statement from the client or legally responsible person granting permission to seek emergency care from a hospital or physician; (7) documentation of progress toward outcomes; (8) if applicable: (A) documentation of physical disorders diagnosis according to International Classification of Diseases (ICD-9-CM); (B) medication orders; (C) orders and copies of lab tests; and (D) documentation or more sand adverse drug reactions. (b) Each facility shall ensure that information relative to AIDS or related conditions is disclosed only in accordance with the communicable	WII KINS I	HOME	1517 PAR	KS VILLAGE R	DAD			
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(D) race, gender and marital status; (E) admission date; (F) discharge date; (2) documentation of mental illness, developmental disabilities or substance abuse diagnosis coded according to DSM IV; (3) documentation of the screening and assessment; (4) treatment/habilitation or service plan; (5) emergency information for each client which shall include the name, address and telephone number of the person to be contacted in case of sudden illness or accident and the name, address and telephone number of the client's preferred physician; (6) a signed statement from the client or legally responsible person granting permission to seek emergency care from a hospital or physician; (7) documentation of services provided; (8) documentation of progress toward outcomes; (9) if applicable: (A) documentation of physical disorders diagnosis according to International Classification of Diseases (ICD-9-CM); (B) medication orders; (C) orders and copies of lab tests; and (D) documentation of medication and administration errors and adverse drug reactions. (b) Each facility shall ensure that information relative to AIDS or related conditions is disclosed only in accordance with the communicable	PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE		COMPLETE	
(E) admission date; (F) discharge date; (2) documentation of mental illness, developmental disabilities or substance abuse diagnosis coded according to DSM IV; (3) documentation of the screening and assessment; (4) treatment/habilitation or service plan; (5) emergency information for each client which shall include the name, address and telephone number of the person to be contacted in case of sudden illness or accident and the name, address and telephone number of the client's preferred physician; (6) a signed statement from the client or legally responsible person granting permission to seek emergency care from a hospital or physician; (7) documentation of services provided; (8) documentation of progress toward outcomes; (9) if applicable: (A) documentation of physical disorders diagnosis according to International Classification of Diseases (ICD-9-CM); (B) medication orders; (C) orders and copies of lab tests; and (D) documentation of medication and administration errors and adverse drug reactions. (b) Each facility shall ensure that information relative to AIDS or related conditions is disclosed only in accordance with the communicable	V 113	Continued From page 3		V 113				
This Rule is not met as evidenced by:		SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 113 Continued From page 3 (D) race, gender and marital status; (E) admission date; (F) discharge date; (2) documentation of mental illness, developmental disabilities or substance abuse diagnosis coded according to DSM IV; (3) documentation of the screening and assessment; (4) treatment/habilitation or service plan; (5) emergency information for each client which shall include the name, address and telephone number of the person to be contacted in case of sudden illness or accident and the name, address and telephone number of the client's preferred physician; (6) a signed statement from the client or legally responsible person granting permission to seek emergency care from a hospital or physician; (7) documentation of services provided; (8) documentation of progress toward outcomes; (9) if applicable: (A) documentation of physical disorders diagnosis according to International Classification of Diseases (ICD-9-CM); (B) medication orders; (C) orders and copies of lab tests; and (D) documentation of medication and administration errors and adverse drug reactions. (b) Each facility shall ensure that information relative to AIDS or related conditions is disclosed only in accordance with the communicable disease laws as specified in G.S. 130A-143.						

Division of Health Service Regulation

failed to maintain documentation of services

STATE FORM 6899 7B4F11 If continuation sheet 4 of 6

Division of Health Service Regulation

DIVISION	or riealiti Service Regu	lation				
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COMPLETED		
		MHL092-299	B. WING		14/4	3/2018
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NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	ATE, ZIP CODE		
WILKINS I	HOME	1517 PAR	KS VILLAGE R	OAD		
WILKING	TIOWIL	ZEBULOI	N, NC 27597			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)
PREFIX	,	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE DATE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROP DEFICIENCY)	KIATE	DAIL
V 113	Continued From page	e 4	V 113			
	provided and failed to	have documentation of				
		omes for 2 of 2 clients (#1				
	and #2). The findings					
	, ,					
	Review on 11/9/18 of	client #1's record revealed:				
	 admission date 	2/21/02				
	- diagnoses of In	tellectual and Developmental				
	Disabilities, Diabetes	• •				
		homa, Hyperlipidemia and				
	Osteoporosis					
	- no documentation of services provided					
	 no documentation of progress towards outcomes in the record 					
	 Review on 11/0/18 of	client #2's record revealed:				
	Review on 11/9/18 of client #2's record revealed: - admission date 8/17/96					
		ild Intellectual and				
	_	vilities, Bipolar Disorder,				
		sthymic Disorder, Gastro				
	Esophageal Reflux D					
	Hyperlipidemia, Chro					
	Tachycardia, Cerebra					
	Status/Post left Hip R					
	 no documentation of services provided no documentation of progress towards outcomes in the record 					
	During an interview o					
	provider/owner report					
	_	s included: slowing down her				
	eating and cutting up					
	decrease pacing; assisting in choosing her own clothes; assisting with chores; assisting with purchases and slowing down her speech - client #2's goals included: decreasing isolation and increasing socialization and maintaining all adult daily living skills					
	- she used to always keep treatment plans					
	and do progress notes but stopped last year at					
the suggestion of the Qualified Professional		1	1		1	

Division of Health Service Regulation

STATE FORM 6899 7B4F11 If continuation sheet 5 of 6

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
MHL092-299			B. WING		11/13/2018	
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	ODRESS, CITY, STA	TE, ZIP CODE		
WILKINS	НОМЕ		RKS VILLAGE RO N, NC 27597	DAD		
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V 113	page 1		V 113			
	Professional reported	had goals for the clients but most of their needs were are they stopped writing out so were not "Innovations" at a plan was necessary of document the services of document progress towards rediately go back to having				

Division of Health Service Regulation

STATE FORM 6899 7B4F11 If continuation sheet 6 of 6