Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
7.1.12 . 27.11	o. oo20		A. BUILDING:				
		MHL058-003	B. WING		11/2	R 8/2018	
NAME OF	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE						
MCLAWI	HORNE HOME		AWHORNE ONVILLE, NO				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE	
V 000	INITIAL COMMENT	ΓS	V 000				
	on 11/28/18. Defici This facility is licens category: 10A NCA	w up survey was completed encies were cited. sed for the following service C 27G .5600C Supervised h Developmental Disabilities.					
V 291	27G .5603 Supervis	sed Living - Operations	V 291				
	10A NCAC 27G .5603 OPERATIONS (a) Capacity. A facility shall serve no more than six clients when the clients have mental illness or developmental disabilities. Any facility licensed on June 15, 2001, and providing services to more than six clients at that time, may continue to provide services at no more than the facility's licensed capacity. (b) Service Coordination. Coordination shall be maintained between the facility operator and the qualified professionals who are responsible for treatment/habilitation or case management. (c) Participation of the Family or Legally Responsible Person. Each client shall be provided the opportunity to maintain an ongoing relationship with her or his family through such means as visits to the facility and visits outside the facility. Reports shall be submitted at least annually to the parent of a minor resident, or the legally responsible person of an adult resident. Reports may be in writing or take the form of a conference and shall focus on the client's progress toward meeting individual goals. (d) Program Activities. Each client shall have activity opportunities based on her/his choices, needs and the treatment/habilitation plan. Activities shall be designed to foster community inclusion. Choices may be limited when the court or legal system is involved or when health or safety issues become a primary concern.						

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 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		MHL058-003	B. WING			R 28/2018	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1044 MCLAWHORNE ROAD ROBERSONVILLE, NC 27871							
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES '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 291	Continued From pa	ge 1	V 291				
	failed to maintain or professionals who a treatment/habilitation clients (#4). The fin Review on 11/27/18 - admitted to the diagnoses of D Hyperlipidemia; Interpretation of intramuscularly one prevention of pneur a written note of pharmacy dated 9/2 waiting list for this withe waiting list and	view and interview the facility pordination with other qualified are responsible for the on of one of three audited dings are: 8 of client #4's record revealed: facility on 7/17/93 inabetes; Hypertension; ellectual Developmental ness lated 9/25/18 "Prevnar 13 .5ml of timeat pharmacy"for the mococcal pneumonia on the prescription from the 25/18 "we currently have a faccine. I placed [client #4] on will call caregiver in a few to his namePrevnar					
	that revealed: - "the vaccine h backorder since Ju get any in stock froi currently keeping a administer to those	as been on manufacturer newe have not been able to m our manufacturer and are running waiting list to patients in need[client #4] is st with 31 patients awaiting of him"					
	all staff take theshe has not foll	11/27/18 staff #1 reported: e clients to their appointments owed up on the Prevnar 13 re his name was on the listor					

Division of Health Service Regulation

STATE FORM 6899 EKFF11 If continuation sheet 2 of 4

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
						R	
		MHL058-003	B. WING		11/2	8/2018	
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
MCLAW	HORNE HOME		AWHORNE ONVILLE, NO				
(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 APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE	
V 291	Continued From page 2		V 291				
	 any staff could have followed up on the Prevnar 13 vaccine she planned to develop a form that would assist staff on following up with future appointments During interview on 11/27/18 staff #2 reported: any staff could have followed up on the Prevnar 13 vaccine, however she has not there was a waiting list at the pharmacy when he was initially taken to get the vaccine she has not followed up to see where his name was on the listor attempted to contact another pharmacy she contacted his physician's office today and client #4 has an appointment for the vaccine on 11/29/18 						
	Service Manager re - she made conta - client #4 was cl	act with the pharmacy today urrently still on the waiting list of the pharmacies could be					
V 752	27G .0304(b)(4) Ho	ot Water Temperatures	V 752				
	EQUIPMENT (b) Safety: Each fa constructed and eq ensures the physica visitors. (4) In areas cexposed to hot water	cility shall be designed, uipped in a manner that al safety of clients, staff and of the facility where clients are er, the temperature of the tained between 100-116 t.					

6899

Division of Health Service Regulation STATE FORM

EKFF11 If continuation sheet 3 of 4

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL058-003	B. WING		11/2	
NAME OF	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 11/28/2018					
MCLAW	HORNE HOME		AWHORNE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
V 752	This Rule is not me Based on observatifailed to ensure war maintained between Observation on 11/2 water temperatures - kitchen sink war - clients' bathroo During interview on - she started in Frand turned the water and turned the water and turned the water - a representative recently had to turn - the water temphowever, steam can too hot" - another water today to check the she would also back out and reche	et as evidenced by: on and interview the facility ter temperatures were in 100-116. The findings are: 27/18 revealed the following is: as 92 m sink was 92 11/27/18 staff #1 reported: February 2018 she started someone came er temperature up 11/27/18 the Residential eported: was purchased in 2017 e from a plumbing company the water down eratures were ran around 115 me from the water"that was hermometer was purchased	V 752			

Division of Health Service Regulation STATE FORM

6899 EKFF11 If continuation sheet 4 of 4