Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		SURVEY LETED			
			A. BOILDING.						
MHL093-058		B. WING		03	03/27/2019				
NAME OF PI	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE								
LAKE ARI	EA COUNSELING HALFV	VAY HOUSE	LKER STREET A, NC 27563						
(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 ACTIC CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE			
V 000	INITIAL COMMENTS An annual survey was completed 3/27/19. No deficiencies were cited. This facility is licensed for the following service		V 000						
	category: 10A NCAC Living for Adults with	27G .5600E Supervised Substance Abuse.							
V 108	27G .0202 (F-I) Perso	onnel Requirements	V 108						
	10A NCAC 27G .0202 PERSONNEL 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; (2) training on client rights and confidentiality as delineated in 10A NCAC 27C, 27D, 27E, 27F and 10A NCAC 26B; (3) training to meet the mh/dd/sa needs of the client as specified in the treatment/habilitation plan; and (4) training in infectious diseases and bloodborne pathogens. (h) Except as permitted under 10a NCAC 27G .5602(b) of this Subchapter, at least one staff member shall be available in the facility at all times when a client is present. That staff member shall be trained in basic first aid including seizure management, 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, investigating and controlling infectious and communicable diseases of personnel and								

Division of Health Service Regulation

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

TITLE (X6) DATE

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL093-058	B. WING		03	/27/2019
NAME OF P	ROVIDER OR SUPPLIER	STREE	T ADDRESS, CITY, STA	TE, ZIP CODE		
LAKE ARI	EA COUNSELING HALF	VAY HOUSE	ALKER STREET INA, NC 27563			
(X4) ID PREFIX TAG			ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE		
V 108	Continued From page clients.	e 1	V 108			
	failed to ensure 1 of 4 maintained certification Pulmonary Resuscitation are: Review on 3/27/19 of revealed:	ew and interview, the facility 4 (#2) audited staff on in 1st Aid and Cardio tion (CPR). The findings				
	expired 2/25/19 During an interview of the had been schedul training in February, 2 been regularly trained He worked on all three	ining certificate which n 3/27/19, staff #2 reported ed to attend a CPR/1st Aid 2019 but missed it. He had d in this area every 2 years. e shifts and worked alone hen the Program Manager				
	Manager (PM) report - staff #2 had be and also on 3/26/19.	en scheduled in February he missed both training due ne program. He will be				
V 110	27G .0204 Training/S Paraprofessionals	Supervision	V 110			
		4 COMPETENCIES AND ARAPROFESSIONALS				

Division of Health Service Regulation

STATE FORM SDCY11 If continuation sheet 2 of 6

Division c	<u>of Health Service Regu</u>	lation					
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING: _					
		MHL093-05	58	B. WING		03/27	/2019
		2000 00		1		1 00/21/	72013
NAME OF PE	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
I AKE ARE	EA COUNSELING HALFV	VAY HOUSE	519 WALK	ER STREET			
	LA GOONGLEMO HALI T	VAI 11000E	NORLINA,	NC 27563			
(X4) ID		ATEMENT OF DEFICIE		ID	PROVIDER'S PLAN OF CORRECTION	١	(X5)
PREFIX	,	Y MUST BE PRECEDE LSC IDENTIFYING INF		PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF		COMPLETE DATE
TAG	REGOLATORI ORE	OO IDENTII TIIVO IIVI	Ordivization)	TAG	DEFICIENCY)	WATE	
				 			
V 110	Continued From page	2		V 110			
	(a) There shall be no	privileging regui	rements for				
	paraprofessionals.	priviloging roqui					
	(b) Paraprofessionals	s shall be superv	ised by an				
	associate professiona	•	•				
	professional as specif	• •					
	Subchapter.						
	(c) Paraprofessionals	s shall demonstra	ite				
	knowledge, skills and						
	population served.	•	•				
	(d) At such time as a	competency-bas	sed				
	employment system is	s established by	rulemaking,				
	then qualified profess						
	professionals shall de						
	(e) Competence shall		ed by				
	exhibiting core skills in	-					
	(1) technical knowled	-					
	(2) cultural awarenes	SS;					
	(3) analytical skills;						
	(4) decision-making;						
	(5) interpersonal skil						
	(6) communication s(7) clinical skills.	Kills, and					
		dy for oach facilit	v shall				
	(f) The governing boo develop and impleme						
	for the initiation of the						
	plan upon hiring each		•				
	plan upon ming cach	paraprofessione					
	This Rule is not met	as evidenced by:					
	Based on record review and interview, 2 of 4						
	Paraprofessional (PP) (#3 and #4) faile	ed to				
	demonstrate knowledge, skills and abilities required to meet the needs of clients served. The						
	findings are:						
	3						

Division of Health Service Regulation

Review on 3/27/19 of staff #3's personnel record

STATE FORM 6899 SDCY11 If continuation sheet 3 of 6

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	
		MHL093-058	B. WING		03	3/27/2019
NAME OF P	ROVIDER OR SUPPLIER	STREE	T ADDRESS, CITY, STAT	ΓΕ, ZIP CODE		
		519 W	ALKER STREET			
LAKE AR	EA COUNSELING HALFV	NAY HOUSE NORL	INA, NC 27563			
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
V 110	Continued From page	e 3	V 110			
	revealed: - hire date 6/1/18 as a Health Care Counselor - a Bachelor's degree in Education in 2013 - trainings including medication training on 6/6/18					
Review on 3/27/19 of staff #4's p revealed: - hire date 5/14/18 as a Heal Counselor - trainings including medication 7/26/18		18 as a Health Care				
	the following example during the previous 3 - 3/1/19 Former dosages of Buprenor because the prescrip - 2/13/19 Client morning medications - Staff #3 working - 1/1/19 "I gave I may have given him questioned him he domust pay closer attenmedications." (Staff - 12/18/18 "2 Buj missing during AM coreported this.	Client (FC) #15 missed phine on 3/1/19 and 2/28/19 tion was not filled on time #5 and #6 missed their when they left early for work e FC #11 his meds per MAR. an extra dose. When I enied he got an extra dose. I attion when administering #4). prenorphine 8mg tabs ount (for FC #13)" Staff #4				
	- 12/12/18 FC # morning dose of Submeeting this client tol him his Suboxone to 12/11/18. That is why on 12/12/18If prope followed the client shomedication in front of	17 did not receive his oxone "Duringmorning d that[Staff #3] had given him in error at 9:30pm on the did not get his 8:00am er procedure had been ould have taken the staff (even if it was the he consumer was handed				

Division of Health Service Regulation

STATE FORM SDCY11 If continuation sheet 4 of 6

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		MHL093-058	B. WING		03/27/2019	
NAME OF P	ROVIDER OR SUPPLIER	STRE	ET ADDRESS, CITY, STATE	E. ZIP CODE	-	
			WALKER STREET	., 0001		
LAKE ARI	EA COUNSELING HALF	FWAY HOUSE	LINA, NC 27563			
(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)		
V 110	Continued From page 4 the 1/2 strip in a medication cup. The staff		V 110			
	member had deliver of making the client #4)	red to the clients room instead present to the office." (Staff				
	Buprenorphine 8mg given by [staff #2]at	taff #4] gave [FC #11] at 8:30pm when it had been 5:30pmProgram Manager tional medication Training."				
	(Staff #4) Note: Specific clien report to maintain the	ts are not identified in this eir anonymity.				
	reported: - staff #3 was o He never interacted the office on the cor their medications. I while administering	etings but never went in with				
	Program Manager re- there had bee when they had seve medication counts for	n a period of time in late 2018 eral incidences of the or Buprenorphine were off. e stopped after a particular				
	- the agency was medication administ #4. - they required additional medication have a record of the emost of the emotion of t	as aware their were tration issues with staff #3 and each staff to attend an on training but they did not				

Division of Health Service Regulation

STATE FORM SDCY11 If continuation sheet 5 of 6

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		i ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING: (X3) DATE COMPI			
		MHL093-058	B. WING		03	/27/2019
	ROVIDER OR SUPPLIER	VAY HOUSE	TREET ADDRESS, CITY, ST. 19 WALKER STREET ORLINA, NC 27563	ATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
V 110	clients obtained a ne leave very early and first day. They imme procedure and they of	w job in which they had to they missed their meds the diately instituted a new lid not miss again. nd #4 would be dealt with	V 110			

Division of Health Service Regulation

STATE FORM SDCY11 If continuation sheet 6 of 6