STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUC AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING:			(X3) DATE SURVEY COMPLETED			
			A. BOILDING.			
		MHL035-029	B. WING		R 03/08/2019	
NAME OF D	DOVIDED OD SUDDI IED	CTDEET AS	DDEEC CITY CTA	TE ZID CODE		
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STA	II E, ZIP CODE		
EASON C	OURT		ON COURT VILLE, NC 2759	96		
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE	BE COMPLETE	
17.0		,	,,,,,	DEFICIENCY)		
V 000	INITIAL COMMENTS		V 000			
		up survey was completed eficiencies were cited.				
		d for the following service 27G .5600A Supervised Mental Illness.				
	A sister facility is iden	tified in this report. The				
	Staff and/or clients wi	entified as sister facility A. Il be identified using the d a numerical identifier.				
V 107	27G .0202 (A-E) Pers	connel Requirements	V 107			
	10A NCAC 27G .0202 REQUIREMENTS	2 PERSONNEL				
	(a) All facilities shall I description for the dire which:	have a written job ector and each staff position				
	competency, work ex					
	qualifications for the p (2) specifies the the position;	osition; duties and responsibilities of				
	•	the staff member and the				
	(b) All facilities shall e	n the staff member's file. ensure that the director,				
	provides care or servi	any other person who ces to clients on behalf of				
	the facility:  (1) is at least 18  (2) is able to rea	s years of age; ad, write, understand and				
	follow directions;	inimum level of education,				
		perience, skills and other				
	qualifications for the p	position; and				
		tantiated findings of abuse or				
	neglect listed on the N	North Carolina Health Care				

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

(X6) DATE TITLE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND FLAN	A. BUILDING:			COINIFILETED		
		MHL035-029	B. WING		03/0	R 18/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
EASON C	OURT	113 EASON		•		
	OLIMANA DV. OT		ILLE, NC 2759			
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
V 107	applicants for employ conviction. The impa decision regarding en upon the offense in rewhich the applicant is (d) Staff of a facility currently licensed, recaccordance with appl services provided.  (e) A file shall be ma employed indicating to	rvices shall require that all ment disclose any criminal ct of this information on a apployment shall be based elationship to the job for applying.  For a service shall be gistered or certified in icable state laws for the intained for each individual he training, experience and r the position, including	V 107			
	This Rule is not met as evidenced by: Based on record review and interview, the governing body failed to ensure 1 of 4 Residential Counselors (RC #7) had no substantiated findings of abuse or neglect listed on the North Carolina Health Care Personnel Registry (HCPR). The findings are:  Note: Staff #7 worked at Sister Facility A in 2018. During a survey dated 10/10/18, this provider was cited for this same situation at Sister Facility A.  Review on 3/6/19 of RC#7's personnel record revealed: - hire date 3/7/17					

Division of Health Service Regulation

STATE FORM 6899 Z4Y811 If continuation sheet 2 of 12

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	MHL035-029	B. WING		R 03/08/2019	
R SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
			96		
ID SUMMARY STATEMENT OF DEFICIENCIES  FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)			(EACH CORRECTIVE ACTION SHOULD	BE COMPLETE	
tiated finding on 7/18/17 2nd HCPR chatiated finding on 7/18/17 Interviews on wed clients reaff person and way.  In interview of the had said duency and interview of the hiring procept of her employ the had so of her employ the her employ the had so one cand above one was not away.	of "Abuse of a Resident"  ack dated 5/14/18 with a of "Abuse of a Resident"  3/6/19 and 3/7/19, 3 of 3 ported RC#7 was a very dishad never mistreated them  an 3/8/19, the AD reiterated ring the survey for the sister 2018: On the HCPR at her hire date by disclosed the incident essely monitored by the AD and ional (QP) for her first 3 or 4 yment through observation  of her top 3 employees. She board in working and ents.  are of and had not received	V 107			
AC 27G .020 JPPLIES itten fire plan de disaster pla approved by y. plan shall be cuation proce n the facility.	for each facility and an shall be developed and the appropriate local made available to all staff edures and routes shall be	V 114			
	SUMMARY ST. EACH DEFICIENCE EGULATORY OR I  ed From page tiated finding on 7/18/17 2nd HCPR ch tiated finding on 7/18/17 nterviews on wed clients re aff person and vay.  an interview o e had said du A) in October C#7 was not o had voluntaril he hiring proc C#7 was close cliffied Professi of her employ pervision C#7 was one er and above g with the clie e was not awa nplaints about 207 Emergence AC 27G .020 JPPLIES itten fire plan de disaster pla approved by y. plan shall be icuation proce in the facility.	MHL035-029  R SUPPLIER  STREET AT  113 EAST YOUNGS  SUMMARY STATEMENT OF DEFICIENCIES EACH DEFICIENCY MUST BE PRECEDED BY FULL EGULATORY OR LSC IDENTIFYING INFORMATION)  ed From page 2  tiated finding of "Abuse of a Resident" on 7/18/17  2nd HCPR check dated 5/14/18 with a tiated finding of "Abuse of a Resident" on 7/18/17  Interviews on 3/6/19 and 3/7/19, 3 of 3  wed clients reported RC#7 was a very aff person and had never mistreated them //ay.  an interview on 3/8/19, the AD reiterated e had said during the survey for the sister A) in October, 2018: C#7 was not on the HCPR at her hire date had voluntarily disclosed the incident her hiring process C#7 was closely monitored by the AD and diffied Professional (QP) for her first 3 or 4 of her employment through observation hervision C#7 was one of her top 3 employees. She er and above board in working and fing with the clients. The was not aware of and had not received haplaints about RC#7  AC 27G .0207 EMERGENCY PLANS JPPLIES itten fire plan for each facility and de disaster plan shall be developed and approved by the appropriate local y. plan shall be made available to all staff focuation procedures and routes shall be	MHL035-029  R SUPPLIER  STREET ADDRESS, CITY, STA  113 EASON COURT YOUNGSVILLE, NC 2758  SUMMARY STATEMENT OF DEFICIENCIES EGULATORY OR LSC IDENTIFYING INFORMATION)  EGULATORY OR LSC IDENTIFYING INFORMATION)  PREFIX TAG  TO 7/18/17  2nd HCPR check dated 5/14/18 with a tiated finding of "Abuse of a Resident" on 7/18/17  2nd HCPR check dated 5/14/18 with a tiated finding of "Abuse of a Resident" on 7/18/17  Interviews on 3/6/19 and 3/7/19, 3 of 3 wed clients reported RC#7 was a very aff person and had never mistreated them vay.  an interview on 3/8/19, the AD reiterated e had said during the survey for the sister A) in October, 2018: C#7 was not on the HCPR at her hire date had voluntarily disclosed the incident he hiring process  C#7 was closely monitored by the AD and liffied Professional (QP) for her first 3 or 4 of her employment through observation vervision  C#7 was one of her top 3 employees. She er and above board in working and gg with the clients. e was not aware of and had not received nplaints about RC#7  207 Emergency Plans and Supplies  V 114  AC 27G .0207 EMERGENCY PLANS JPPLIES itten fire plan for each facility and de disaster plan shall be developed and approved by the appropriate local y. plan shall be made available to all staff icuation procedures and routes shall be in the facility.	R SUPPLIER  ### STREET ADDRESS, CITY, STATE, ZIP CODE  113 EASON COURT YOUNGSVILLE, NC 27596  SUMMARY STATEMENT OF DEFICIENCIES EACH DEFICIENCY MUST BE PRECEDED BY FULL EGULATORY OR LSC IDENTIFYING INFORMATION)  ### PREFIX TAG  PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)  ### OT 7/18/17  AD 117  A	

Division of Health Service Regulation

STATE FORM 6899 Z4Y811 If continuation sheet 3 of 12

STATEMENT OF DEFICIENCIES  AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN (	OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING:			COMPLETED			
		MHL035-029	B. WING		R <b>03/08/2019</b>		
NAME OF D	ROVIDER OR SUPPLIER				03/06/2019		
NAME OF P	ROVIDER OR SUPPLIER	113 EASO	DRESS, CITY, STA N COURT	ITE, ZIP CODE			
EASON C	OURT		/ILLE, NC 2759	96			
(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 CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	D BE COMPLETE		
V 114	under conditions that		V 114				
	failed to conduct fire a quarterly on each shift During an interview o Manager (RM) report disaster drills were as - 1st - 8:00am - 4	ew and interview, the facility and disaster drills at least it. The findings are:  n 3/4/19, the Residential ed the shifts for fire and s follows:					
	were not conducted of third shift during (April - June, 2019 and 2019)	8:00am.  the fire drill log revealed drills  the 2nd and 4th Quarter d October - December,  the 3rd and 4th Quarter					
	drills were not conduct - second shift during - third shift during - first shift during  During interviews on a clients reported drills	ring the 3rd Quarter g the 2nd and 3rd Quarters the 4th Quarter 3/6/19 and 3/7/19, 3 of 3 were done monthly.					
	During an interview o	n 3/6/19, the Residential					

Division of Health Service Regulation

STATE FORM 6899 Z4Y811 If continuation sheet 4 of 12

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		
	MHL035-029 B. WING		R <b>03/08/2019</b>		
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STATE	, ZIP CODE	
EASON C	OURT		ON COURT		
	1	YOUNGS	SVILLE, NC 27596		
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE COMPLETE
V 114	Continued From page	e 4	V 114		
	monthly on each shift corrections and chan immediately.  This deficiency is cro NCAC 27G .0303 Factors and chan immediately.	ss referenced into 10A cility Grounds and for a Type B and must be			
V 119	27G .0209 (D) Medic	ation Requirements	V 119		
	V 119  27G .0209 (D) Medication Requirements  10A NCAC 27G .0209 MEDICATION REQUIREMENTS (d) Medication disposal: (1) All prescription and non-prescription medication shall be disposed of in a manner that guards against diversion or accidental ingestion. (2) Non-controlled substances shall be disposed of by incineration, flushing into septic or sewer system, or by transfer to a local pharmacy for destruction. A record of the medication disposal shall be maintained by the program. Documentation shall specify the client's name, medication name, strength, quantity, disposal date and method, the signature of the person disposing of medication, and the person witnessing destruction. (3) Controlled substances shall be disposed of in accordance with the North Carolina Controlled Substances Act, G.S. 90, Article 5, including any subsequent amendments. (4) Upon discharge of a patient or resident, the remainder of his or her drug supply shall be disposed of promptly unless it is reasonably expected that the patient or resident shall return to the facility and in such case, the remaining drug supply shall not be held for more than 30				

Division of Health Service Regulation

STATE FORM 6899 Z4Y811 If continuation sheet 5 of 12

AND PLAN OF CORRECTION   IDENTIFICATION NUMBER:   A. BUILDING:    MHL035-029   B. WING	COMPLETED  R  03/08/2019
MHI 035 030 B. WING	I
	03/06/2019
MITEUSS-029	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
EASON COURT  YOUNGSWILE NO 27505	
YOUNGSVILLE, NC 27596	U O S O O D D S O S O O O O O O O O O O O
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED	N OF CORRECTION (X5) E ACTION SHOULD BE COMPLETE TO THE APPROPRIATE DATE  DATE
V 119 Continued From page 5 V 119	
This Rule is not met as evidenced by:  Based on observation record review and interview, the facility failed to ensure that all	
prescription and non-prescription medications were disposed of in a manner that guarded against diversion or accidental ingestion affecting.	
The findings are:	
Observation on 3/6/19 at 11:30am of the facility's medication cabinet revealed 2 plastic containers filled with a base of cat litter and an extensive	
amount and variety of pills and capsules. The pills were round or oblong shaped, red, yellow,	
green, white and there were capsules colored	
white/peach, white/blue and white and green.  There was no documentation on the containers of	
what was contained in the container.	
A. Review on 3/6/19 of client #1's record revealed medication disposal sheets. These included:	
a. Date of Medication Disposal Sheet:  12/4/18	
Medication: Seroquel 200mg - 1 pill Reason for disposal: Medication	
Discontinued	
b. Date of Medication Disposal Sheet: 11/23/18	
Medication: Clonazapam 1mg 1 pill Reason for disposal: Medication	
Discontinued	
c. Date of Medication Disposal Sheet: 10/16/18	
Medication: Savoys 30mg 9 pills Reason for disposal: Medication Discontinued	

Division of Health Service Regulation

STATE FORM 6899 Z4Y811 If continuation sheet 6 of 12

DIVISION	n nealth Service Regu	lation				
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SU		
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
				l 5		
		MUU OOF OOO	B. WING		R	2/0040
		MHL035-029			03/08	3/2019
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	ATE, ZIP CODE		
		113 EASC	N COURT			
EASON C	OURT		/ILLE, NC 2759	96		
	OUR MAR DV OT					
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
TAG		LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR		DATE
				DEFICIENCY)		
V 440	0 " 15		1/440			
V 119	Continued From page	9 6	V 119			
	d. Date of Medica	ation Disposal Sheet:				
	10/16/18	•				
	Medication: A	ctors 30mg 9 pills				
		sposal: Medication				
	Discontinued	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				
		ation Disposal Sheet:				
	9/19/18	2.00 2.00 cm				
		lonazapam 0.5mg 22 pills				
		sposal: Medication				
	Discontinued	poda. Medidation				
		ation Disposal Sheet:				
	8/30/19	ation Biopodai Gilect.				
	Medication: C	lonazapam 0.5mg 34 pill				
		sposal: Overstock				
	f. Date of Medica	ation Disposal Sheet: no				
	date listed	·				
	Medication: C	lonazapam 0.5mg 59 pills				
		sposal: Overstock				
		ation Disposal Sheet: no				
	date listed	•				
	Medication: C	lonazapam 0.5mg 30 pills				
		sposal: Overstock				
	B. Review on 3/6/19 of	of client #3's record revealed				
	medication disposal s	sheets. These included:				
	•	ation Disposal Sheet:				
	10/27/18	·				
	Medication: D	epakote 500mg - 1 pill				
		sposal: Overstock				
		ation Disposal Sheet:				
	10/27/18	•				
		razadone 150mg 9 pills				
		sposal: Overstock				
		ation Disposal Sheet:				
	12/25/18	2.00000				
		lozapine 100mg 6 pills				
		sposal: Medication				
	Discontinued					
		ation Disposal Sheet:				

Division of Health Service Regulation

6/28/18

STATE FORM 6899 Z4Y811 If continuation sheet 7 of 12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X		(X3) DATE SURVEY COMPLETED	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING: _		COMILLIED	
				R		
		MHL035-029	B. WING		03/08/2019	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
EACON C	OUDT	113 EASC	N COURT			
EASON C	JURI	YOUNGS	VILLE, NC 2759	96		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
V 119	Continued From page	÷ 7	V 119			
V 119	Medication: Ta Reason for dis e. Date of Medica 6/28/18 Medication: La Reason for dis f. Date of Medica 6/28/18 Medication: La Reason for dis g. Date of Medica 6/28/18 Medication: Da Reason for dis C. Review on 3/6/19 of medication disposal sa a. Date of Medica 5/16/18 Medication: Ta Reason for dis Discontinued b. Date of Medica Medication: La	amsulosin 0.4mg 1 pill aposal: Medication Expired ation Disposal Sheet:  amotrigine 25mg 2 pills aposal: Medication Expired ation Disposal Sheet:  amotrigine 100mg 1 pill aposal: Medication Expired ation Disposal Sheet:  appeared by the property of client #4's record revealed ation Disposal Sheet:  azadone 50mg 14 pills aposal: Medication ation Disposal Sheet:  azadone 50mg 14 pills aposal: Medication ation Disposal Sheet: 4/2/18 apposal: Medication ation Disposal Sheet: 4/2/18 apposal: Medication	V 119			
	c. Date of Medica	ation Disposal Sheet:				
	Medication: C Reason for dis	lozapine 50mg 21 pills posal: Medication				
	Discontinued d. Date of Medication Disposal Sheet: 6/28/18 Medication: Lorazepam 1mg 8 pills Reason for disposal: Overstock					
	above sheets were si	3/6/19 revealed each of the gned by the staff disposing the jug and a staff witness.				

Division of Health Service Regulation

STATE FORM 6899 Z4Y811 If continuation sheet 8 of 12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		MHL035-029	B. WING		R 03/08/2019
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD			,
(X4) ID PREFIX	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ILLE, NC 2759	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	BE COMPLETE
TAG	REGULATORY OR I	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	RIATE DATE
V 119	- when a medical discontinued, staff we blister pack into one of This same staff person Medication Disposal I was a controlled med present when the me containers and both staff of the containers and the contained medicated disposal. She did not thrown away or the contained in the contained by the contained of the medical contained by the contained by	in 3/6/19, staff #1 reported: tion was changed or build empty the pills from the of the above containers. In would complete the Form (MDF) and sign it. If it ication 2 staff needed to be dications were put in the staff needed to sign the were kept in the locked  Manager (RM) would take ions to the landfill for t know if the container was ontainer was emptied at the  I the concern about possible cations  In 3/6/19, the RM reported:	V 119		
	During an interview on 3/6/19, the RM reported:     - all staff had access to the medication cabinet     - when a client's dose had changed or a medication had been discontinued, staff #1 would take the pills/capsules off the blister pack and put them in the plastic container     - it was the Qualified Professional (QP) who would take discontinued medications to the landfill for disposal. She did not know if the container was thrown away or the container was emptied at the landfill     - 2 staff needed to be present and sign for the disposal of controlled medications  During an interview on 3/7/19, the QP reported:     - they had changed their method of disposal after a previous surveyor told them to put expired/discontinued medications in something like cat litter or coffee grounds to dissuade				

Division of Health Service Regulation

STATE FORM 6899 Z4Y811 If continuation sheet 9 of 12

STATEMEN	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE		(X3) DATE SURVEY		
AND PLAN	ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING: _		COMPLE	TED	
					R		
		MHL035-029	B. WING		03/08/2019		
NAME OF D	PROVIDER OR SUPPLIER	•	DRESS, CITY, STAT	TE ZIR CODE	1		
NAME OF T	NOVIDEN ON 3011 FIEN	113 EASO		TE, ZII GODE			
EASON C	OURT		/ILLE, NC 2759	6			
	OLIMANA DV. OZ						
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	) BE	(X5) COMPLETE DATE	
V 119	Continued From page	e 9	V 119				
	diversion - prior to that the medications in the bl them to the pharmac - felt they were gabout the disposal of  During an interview of Director reported: - they disposed in this manner after be Sister Facility A - acknowledged the medication cabin without anyone being they would imm	ey had been leaving the ister pack and returning y given conflicting information medications on 3/8/19, the Assistant of discontinued medications being cited for the same at that anyone with access to et could take the pills out					
V 736	diversion  27G .0303(c) Facility and Grounds Maintenance  10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS (c) Each facility and its grounds shall be maintained in a safe, clean, attractive and orderly manner and shall be kept free from offensive odor.  This Rule is not met as evidenced by: Based on observation and interview, the governing body failed to maintain the facility in a safe manner. The findings are:  Cross Reference: 10A NCAC 27G .0207 Emergency Plans and Supplies (Tag V114).		V 736				
V 736	10A NCAC 27G .030 EXTERIOR REQUIR (c) Each facility and i maintained in a safe, manner and shall be odor.  This Rule is not met Based on observation governing body failed safe manner. The fir Cross Reference: 10 Emergency Plans and	3 LOCATION AND EMENTS Its grounds shall be clean, attractive and orderly kept free from offensive  as evidenced by: n and interview, the d to maintain the facility in a ndings are:  A NCAC 27G .0207	V 736				

Division of Health Service Regulation

STATE FORM 6899 Z4Y811 If continuation sheet 10 of 12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CO	DNSTRUCTION		E SURVEY PLETED	
		MHL035-029	B. WING		0:	R 3/ <b>08/2019</b>
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
EASON C	COURT		ON COURT SVILLE, NC 27596			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
V 736	failed to conduct fire quarterly on each shad on the opened of a keyed lock soutside. This door of the inside.  - a window in the chest high and could exited in the case of the outside of the sliding door.  During an interview of the sliding doors during drills. Since the sliding drills. Since the sliding drills of the sliding drills. Since the sliding drills of the sliding drills of the sliding drills of the sliding drills of the sliding drills. Since the sliding drills of the	and disaster drills at least iff.  19 at 3:30pm revealed: In client #1's bedroom which ecured on the slider on the ould not be unlocked from e adjoining bathroom was I not be easily be opened or an emergency on 3/6/19, client #1 reported: be able the climb out of the case of a fire "burn up and die" if there was droom door and she could go on 3/7/19, staff #2 reported of long the lock had been on der in client #1's bedroom. We client #1 would exit if there er bedroom door. He had not bught it was able to be on 3/6/19, staff #1 reported one sliding door could not be anys used the front or back is she could not say how client was a fire outside her thought the bathroom	V 736			

Division of Health Service Regulation

STATE FORM 6899 Z4Y811 If continuation sheet 11 of 12

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	CONSTRUCTION	(X3) DATE S COMPLI	
		MHL035-029	B. WING		R 03/0	8/2019
NAME OF P	ROVIDER OR SUPPLIER		L RESS, CITY, STA	TE, ZIP CODE	1 03/0	0/2013
EASON C	OURT	113 EASON YOUNGSVI	I COURT LLE, NC 2759	96		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
V 736	unlocked which he die be manually locked frable to access the outemergency.  Review on 3/7/19 of a written/signed and su Professional on 3/7/1 protection ensures (1 Eason Court Youngsvexits per requirement master bedroom of 1 NC 27596 will not be An independent controbstructions from the bedroom, on today Mexiting."  "The governing body environment at the fameans of egress from There were sliding glabedroom which had a prevented the door froinside. In addition the the required number of have allowed clients the exit the facility in case governing body in allowithout correction was health and safety. The Type B rule violation corrected within 45 dapenalty of \$200.00 per series of the control of the corrected within 45 dapenalty of \$200.00 per series.	d. The slider door could still om inside so client #1 was tside in the case of an  a Plan of Protection bmitted by the Qualified 9 revealed: "This plan of ) the master bedroom of 113 ville, NC 27596 will have two s (2) the sliding door in the 13 Eason Court Youngsville, obstructed in any manner. Factor will remove all sliding door, in the master arch 7th allowing safe  failed to maintain a safe cility by locking the second in the master bedroom. The master bedroom is second in the master bedroom. The failed to maintain of fire drills which would to practice different ways to be of a fire. The failure of the owing this to continue is detrimental to clients his deficiency constitutes a	V 736			

Division of Health Service Regulation

STATE FORM 6899 Z4Y811 If continuation sheet 12 of 12