STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL001-251	A. BUILDING: _____ B. WING _____	R 05/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LILLIES PLACE #2	121 HAZEL DRIVE BURLINGTON, NC 27217

(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 000	INITIAL COMMENTS An annual and follow up survey was completed on May 7, 2019. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G. 5600A Supervised Living for Adults with Mental Illness	V 000		
V 112	27G .0205 (C-D) Assessment/Treatment/Habilitation Plan 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.	V 112		

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V 114	Continued From page 2 posted in the facility. (c) Fire and disaster drills in a 24-hour facility shall be held at least quarterly and shall be repeated for each shift. Drills shall be conducted under conditions that simulate fire emergencies. (d) Each facility shall have basic first aid supplies accessible for use. This Rule is not met as evidenced by: Based on record review and interview the facility failed to conduct fire and disaster drills on each shift at least quarterly. The findings are: Request on 4/29/19 for the facility's fire and disaster drills records revealed: - There were no documentation a fire and disaster drill was conducted at least quarterly on each shift. Interview on 5/6/19 with the Licensee revealed: - She said fire and disaster drills were being conducted. - She would submit a copy of the fire and disaster drill record for review. The record of fire and disaster drils conducted in the fascility for the past year was not submitted prior to the close of the survey. This deficiency constitutes a recited deficiency and must be corrected within 30 days.	V 114	Lillies Place had Fire drills and the Fire drills were in the Facility at the time of the survey But the employee that was PRN and didn't know where they were located at the time of the survey. Fire drills are and have been conducted Per Staff quarterly on each shift along with a disaster drill. In order to not have this recited	
V 536	27E .0107 Client Rights - Training on Alt to Rest. Int. 10A NCAC 27E .0107 TRAINING ON	V 536		

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V 536	Continued From page 4 disabilities; (4) strategies for building positive relationships with persons with disabilities; (5) recognizing cultural, environmental and organizational factors that may affect people with disabilities; (6) recognizing the importance of and assisting in the person's involvement in making decisions about their life; (7) skills in assessing individual risk for escalating behavior; (8) communication strategies for defusing and de-escalating potentially dangerous behavior; and (9) positive behavioral supports (providing means for people with disabilities to choose activities which directly oppose or replace behaviors which are unsafe). (h) Service providers shall maintain documentation of initial and refresher training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcomes (pass/fail); (B) when and where they attended; and (C) instructor's name; (2) The Division of MH/DD/SAS may review/request this documentation at any time. (i) Instructor Qualifications and Training Requirements: (1) Trainers shall demonstrate competence by scoring 100% on testing in a training program aimed at preventing, reducing and eliminating the need for restrictive interventions. (2) Trainers shall demonstrate competence by scoring a passing grade on testing in an instructor training program. (3) The training shall be competency-based, include measurable learning	V 536	pre Formed as required. This defiency has been corrected and placed in proper location for viewing. 5/7/19 CC This defiency has been corrected Staff (KJ) has attended her Refresher cource on NCI which is is now (EBPI) Interventions-BASE Plus. A copy has been Faxed placed inside of her Files. Admin will Asure that this problem or reated doesn't reccur	

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V 536	Continued From page 6 requirements as a trainer. (2) Coaches shall teach at least three times the course which is being coached. (3) Coaches shall demonstrate competence by completion of coaching or train-the-trainer instruction. (I) Documentation shall be the same preparation as for trainers. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility management failed to assure 1 of 3 audited staff (#1) had current training in alternatives to restrictive interventions. The findings are: Review on 4/29/19 of Staff #1's record revealed: - Hire date of 7/20/17 - Documentation of training in alternatives to restrictive interventions was dated 6/23/17. The training was expired. During interview on 5/3/19, the Licensee/Qualified Professional said: - She thought the staff's training was current. - She would check and immediately provide the requested documentation if the staff had received an annual retraining as required. No additional documentation of Staff #1's updated training in alternatives to restrictive interventions was received by the close of the survey on 5/7/19.	V 536		

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V 536	Continued From page 5 objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (4) The content of the instructor training the service provider plans to employ shall be approved by the Division of MH/DD/SAS pursuant to Subparagraph (i)(5) of this Rule. (5) Acceptable instructor training programs shall include but are not limited to presentation of: (A) understanding the adult learner; (B) methods for teaching content of the course; (C) methods for evaluating trainee performance; and (D) documentation procedures. (6) Trainers shall have coached experience teaching a training program aimed at preventing, reducing and eliminating the need for restrictive interventions at least one time, with positive review by the coach. (7) Trainers shall teach a training program aimed at preventing, reducing and eliminating the need for restrictive interventions at least once annually. (8) Trainers shall complete a refresher instructor training at least every two years. (j) Service providers shall maintain documentation of initial and refresher instructor training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcomes (pass/fail); (B) when and where attended; and (C) instructor's name. (2) The Division of MH/DD/SAS may request and review this documentation any time. (k) Qualifications of Coaches: (1) Coaches shall meet all preparation	V 536	By Renewing Staff Files quarterly but QP will renew monthly to ASSure theres no oversight. (Lillies PLACE employee had gotten SICK And had to leave work PRN KJ came in to relieve her unknowingly that her certification had expired. But client had attended a class and Recieved her Certificate It was faxed but will be refaxed. Admin will assure all documentations, certificate are located in an area in which they can be located. All deficiencies have been corrected and QP will monitor and renew quarter to assure Everything is in compliance. CC 5/7/19	

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V 536	Continued From page 3 ALTERNATIVES TO RESTRICTIVE INTERVENTIONS (a) Facilities shall implement policies and practices that emphasize the use of alternatives to restrictive interventions. (b) Prior to providing services to people with disabilities, staff including service providers, employees, students or volunteers, shall demonstrate competence by successfully completing training in communication skills and other strategies for creating an environment in which the likelihood of imminent danger of abuse or injury to a person with disabilities or others or property damage is prevented. (c) Provider agencies shall establish training based on state competencies, monitor for internal compliance and demonstrate they acted on data gathered. (d) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (e) Formal refresher training must be completed by each service provider periodically (minimum annually). (f) Content of the training that the service provider wishes to employ must be approved by the Division of MH/DD/SAS pursuant to Paragraph (g) of this Rule. (g) Staff shall demonstrate competence in the following core areas: (1) knowledge and understanding of the people being served; (2) recognizing and interpreting human behavior; (3) recognizing the effect of internal and external stressors that may affect people with	V 536	the Administrator will exit the survey and place in the Surveyors hands Items requested. It was my understand that this file was located during the time of survey But For futhel Refrence All staff will be trained On where all records are kept In case Admin isn't Available. QP will renew every other month to assure they are being	

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V 112	Continued From page 1 This Rule is not met as evidenced by: Based on record reviews and interview, the facility failed to complete a treatment plan annually for one of three audited clients (#1). The findings are: Review on 4/29/19 of Client #1's record revealed: - Admission date of 8/10/18. - Diagnoses of Schizophrenia; Borderline Hyperglycemia; Hypothyroidism; Hyperlipidemia and Diabetes, Type II. - The treatment plan in the client's record was last completed on 9/21/17. Interview on 5/6/19 with the Licensee revealed: - The Qualified Professional was responsible for updating treatment plans. - She believed the treatment plan had been updated. - She would submit an updated copy of the treatment plan for review. The annually updated treatment plan for Client #1 was not submitted prior to the close of the survey. This deficiency constitutes a recited deficiency and must be corrected within 30 days.	V 112	This deficency has been corrected. An updated PCP has been signed and placed in the Clients treatment book. In order For this to not reoccur the Administrator has and will continue to monitor the plans bi monthy to renew dates, changes or updates The QP will renew Quarterly to assure that this defiency will not reoccur. 5/7/19 CC	
V 114	27G .0207 Emergency Plans and Supplies 10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES (a) A written fire plan for each facility and area-wide disaster plan shall be developed and shall be approved by the appropriate local authority. (b) The plan shall be made available to all staff and evacuation procedures and routes shall be	V 114		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
MHL001-251 Y1	A. Building B. Wing Y2	5/7/2019 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
LILLIES PLACE #2	121 HAZEL DRIVE BURLINGTON, NC 27217

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix V0133 Reg. # G.S. 122C-80 LSC	Correction Completed 05/07/2019	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) MMC	DATE 5/7/19	SIGNATURE OF SURVEYOR MAryland M. Chenier	DATE 5/7/19
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 4/26/2018	☒ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☒ YES ☐ NO			

Att. Maryland M Chener

NC DEPARTMENT OF
HEALTH AND HUMAN SERVICES

ROY COOPER • Governor
MANDY COHEN, MD, MPH • Secretary
MARK PAYNE • Director, Division of Health Service Regulation

May 10, 2019

Ms. Cherry Crisp, Administrator
Lillies Place #2, Inc
121 Hazel Drive
Burlington, NC 27217

Re: Annual and Follow up Survey completed May 7, 2019
Lillies Place #2, 121 Hazel Drive, Burlington, NC 27217
MHL # 001-251
E-mail Address: cherrycrisp1968@gmail.com

Dear Ms. Crisp:

Thank you for the cooperation and courtesy extended during the annual and follow up survey completed May 7, 2019.

As a result of the follow up survey, it was determined that some of the deficiencies are now in compliance, which is reflected on the enclosed Revisit Report. Additional deficiencies were cited during the survey.

Enclosed you will find all deficiencies cited listed on the Statement of Deficiencies Form. The purpose of the Statement of Deficiencies is to provide you with specific details of the practice that does not comply with state regulations. You must develop one Plan of Correction that addresses each deficiency listed on the State Form, and return it to our office within ten days of receipt of this letter. Below you will find details of the type of deficiencies found, the time frames for compliance plus what to include in the Plan of Correction.

Type of Deficiencies Found

- Re-cited standard level deficiencies.
- All other tags cited are standard level deficiencies.

Time Frames for Compliance

- Re-cited standard level deficiencies must be ***corrected*** within 30 days from the exit of the survey, which is June 6, 2019.
- Standard level deficiencies must be ***corrected*** within 60 days from the exit of the survey, which is July 8, 2019.