PRINTED: 05/22/2019 FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED	
		MHL0601376	B. WING		05	/22/2019	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	E, ZIP CODE			
THE MEN.	DILL LIONE	11933 W	ATERPERRY COU	RT			
THE NEW	BILL HOME	HUNTER	SVILLE, NC 2807	8			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	ORRECTION	(X5)	
PRÉFIX TAG	, -	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	E APPROPRIATE	COMPLETE DATE	
V 000	INITIAL COMMENTS		V 000				
	An annual survey was completed on May 22, 2019. Deficiencies were cited.						
	This facility is licensed for the following service category: 10A NCAC 27G .5600F Alternative Family Living for Individuals with Developmental Disabilities.						
V 108	/ 108 27G .0202 (F-I) Personnel 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,						

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) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL0601376	B. WING		05/22/2019	
NAME OF PI	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE, ZIP CODE	1 03/2/	2/2013
THE NEWBILL HOME 11933 WATERPERRY COURT						
		HUNTERS	VILLE, NC 280	78		
(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 CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
V 108	Continued From page 1		V 108			
	and communicable di clients.	seases of personnel and				
	This Rule is not met as evidenced by: Based on interview and record review, the facility failed to ensure staff training to ensure the needs of the clients affecting 2 of 2 staff (Alternative Family Living Provider and Qualified Professional). The findings are:					
	Review on 5/20/2019 of Client #1's record revealed: -Admission date of 4/5/2019; -Diagnoses of Attention Deficit Hyperactivity Disorder, Intellectual Developmental Disability - Severe, Neglect by History, Fine Motor Functioning Deficits, Epilepsy, Reduced Muscle Tone and Gait, Mild Diabetes, Speech Disorder; -Biological father is currently in prison due to neglect and sexual abuse of Client #1; -Client #1 has a history of public exposure of herself in a sexual manner; -Removed from last placement due to reports of masturbation, 2 incidents of sexual behaviors with young children, and getting into bed with a younger child and attempted to remove the child's underwear and kiss the child.					
	Review on 5/20/2019 Living Provider's reco -Hire date of 11/11/20 -No documentation of Aggressive/Sexually Review on 5/20/2019	09; f training in Sexually Reactive Youth.				

Division of Health Service Regulation

Professional's record revealed:

STATE FORM 6899 1BWF11 If continuation sheet 2 of 4

Division of Health Service Regulation

Division of fleatin Service Regulation				CONSTRUCTION	OVO. BATE OUBLEY
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND FLAN OF CORRECTION IDENTIFICATION NOWIBER.		A. BUILDING:		OOMI LETED	
MHL0601376		B. WING		05/22/2019	
			1		
NAME OF PR	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE	
THE NEW	BILL HOME	11933 WA	ERPERRY CO	URT	
	51221101112	HUNTERS	VILLE, NC 280	78	
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
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TAG	REGULATURY OR L	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE DATE
				,	
V 108	Continued From page	2	V 108		
	Llina data of 12/2/201	10.			
	-Hire date of 12/3/201	•			
	-No documentation of	•			
	Aggressive/Sexually I	Reactive Youth.			
	Interview on E/20/204	O with the Comparate			
	Interview on 5/20/201	•			
	Compliance Officer re				
		Alternative Family Living			
		d Professional will have the			
		e needs of the sexually			
	active/sexually reactive	ve youth.			
V 112	27G .0205 (C-D)		V 112		
	Assessment/Treatme	nt/Habilitation Plan			
	10A NCAC 27G .0205	5 ASSESSMENT AND			
	TREATMENT/HABILI	TATION OR SERVICE			
	PLAN				
	(c) The plan shall be	developed based on the			
		artnership with the client or			
		erson or both, within 30 days			
		ts 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					
		ieveriierit,			
	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

STATE FORM 6899 1BWF11 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	
		MIII 0004070	B. WING _			
		MHL0601376			05/22/2019	
NAME OF P	ROVIDER OR SUPPLIER		RESS, CITY, STA ERPERRY CO			
THE NEW	BILL HOME		VILLE, NC 280			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE COM TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
V 112	Continued From page	∋ 3	V 112			
	This Rule is not met as evidenced by: Based on interview and record review, the facility failed to develop and implement strategies to address the needs of the clients affecting 1 of 1 client (Client #1). The findings are: Review on 5/20/2019 of Client #1's record revealed: -Admission date of 4/5/2019; -Diagnoses of Attention Deficit Hyperactivity Disorder, Intellectual Developmental Disability - Severe, Neglect by History, Fine Motor					
	Functioning Deficits, Tone and Gait, Mild E -Biological father is or neglect and sexual at -Client #1 has a histo herself in a sexual ma -Removed from last p masturbation, 2 incide young children, and g	Epilepsy, Reduced Muscle Diabetes, Speech Disorder; urrently in prison due to ouse of Client #1; ry of public exposure of anner; Diacement due to reports of ents of sexual behaviors with getting into bed with a empted to remove the child's he child; d 4/10/2019 had no to address Client #1's				
	Compliance Officer re- -Will ensure that the 0	evealed: Client #1's treatment plan is atment strategies to address				

Division of Health Service Regulation

STATE FORM 6899 1BWF11 If continuation sheet 4 of 4