

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL064-148	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 06/05/2019
--	---	---	---

NAME OF PROVIDER OR SUPPLIER MOORE HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 3619 COOLEY LANE NASHVILLE, NC 27856
--	--

(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	<p>INITIAL COMMENTS</p> <p>An annual & follow up survey was completed on 6/5/19. Deficiencies were cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G 5600F Supervised Living/Alternative Family Living</p>	V 000		
V 118	<p>27G .0209 (C) Medication Requirements</p> <p>10A NCAC 27G .0209 MEDICATION REQUIREMENTS</p> <p>(c) Medication administration:</p> <p>(1) Prescription or non-prescription drugs shall only be administered to a client on the written order of a person authorized by law to prescribe drugs.</p> <p>(2) Medications shall be self-administered by clients only when authorized in writing by the client's physician.</p> <p>(3) Medications, including injections, shall be administered only by licensed persons, or by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer medications.</p> <p>(4) A Medication Administration Record (MAR) of all drugs administered to each client must be kept current. Medications administered shall be recorded immediately after administration. The MAR is to include the following:</p> <p>(A) client's name;</p> <p>(B) name, strength, and quantity of the drug;</p> <p>(C) instructions for administering the drug;</p> <p>(D) date and time the drug is administered; and</p> <p>(E) name or initials of person administering the drug.</p> <p>(5) Client requests for medication changes or checks shall be recorded and kept with the MAR file followed up by appointment or consultation with a physician.</p>	V 118		

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 AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL064-148	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 06/05/2019
--	---	---	---

NAME OF PROVIDER OR SUPPLIER MOORE HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 3619 COOLEY LANE NASHVILLE, NC 27856
--	--

(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 118	<p>Continued From page 1</p> <p>This Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure one of three clients (#3) self administered his medication on the written order of a physician. The findings are:</p> <p>Review on 5/3/19 of client #3's record revealed:</p> <ul style="list-style-type: none"> - admitted to the facility 12/12/18 - diagnoses of Mood Disorder; Autism; Anxiety & Depression - a treatment plan dated 12/27/18 "Fluoxetine 20mg every morning" (can treat depression & anxiety) signed by a physician..."requires assistance with medication management" <p>During interview on 5/3/19 the Licensee reported:</p> <ul style="list-style-type: none"> - client #3 resided at an onsite campus away from the facility - he attended a school that assisted with on the job work skills - client #3 was on one medication - he self administered his own medication - he was his own guardian - she spoke with a staff at the residential onsite campus - the staff agreed to observe client #3 take his medication - staff would sign a form he took the medication - she would obtain a self administer order from client #3's physician <p>During interview on 5/3/19 the case management Qualified Professional reported:</p> <ul style="list-style-type: none"> - client #3 was on 1 medication "Fluoxetine" 	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL064-148	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 06/05/2019
--	---	---	---

NAME OF PROVIDER OR SUPPLIER MOORE HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 3619 COOLEY LANE NASHVILLE, NC 27856
--	--

(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 118	<p>Continued From page 2</p> <ul style="list-style-type: none"> - she was not aware he self administered the medication - she thought the residential staff at the program administered client #3's medication <p>During interview on 6/5/19 a representative at the onsite job skill program reported:</p> <ul style="list-style-type: none"> - staff does not administered client medications - clients are required to independently take their own medications - staff are not trained to administer client's medications <p>During interview on 6/5/19 the Licensee reported:</p> <ul style="list-style-type: none"> - she obtained a self administer order from client #3's physician <p>[This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.]</p>	V 118		
V 290	<p>27G .5602 Supervised Living - Staff</p> <p>10A NCAC 27G .5602 STAFF</p> <p>(a) Staff-client ratios above the minimum numbers specified in Paragraphs (b), (c) and (d) of this Rule shall be determined by the facility to enable staff to respond to individualized client needs.</p> <p>(b) A minimum of one staff member shall be present at all times when any adult client is on the premises, except when the client's treatment or habilitation plan documents that the client is capable of remaining in the home or community without supervision. The plan shall be reviewed as needed but not less than annually to ensure the client continues to be capable of remaining in the home or community without supervision for specified periods of time.</p> <p>(c) Staff shall be present in a facility in the</p>	V 290		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL064-148	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 06/05/2019
--	---	---	---

NAME OF PROVIDER OR SUPPLIER MOORE HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 3619 COOLEY LANE NASHVILLE, NC 27856
--	--

(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 290	<p>Continued From page 3</p> <p>following client-staff ratios when more than one child or adolescent client is present:</p> <p>(1) children or adolescents with substance abuse disorders shall be served with a minimum of one staff present for every five or fewer minor clients present. However, only one staff need be present during sleeping hours if specified by the emergency back-up procedures determined by the governing body; or</p> <p>(2) children or adolescents with developmental disabilities shall be served with one staff present for every one to three clients present and two staff present for every four or more clients present. However, only one staff need be present during sleeping hours if specified by the emergency back-up procedures determined by the governing body.</p> <p>(d) In facilities which serve clients whose primary diagnosis is substance abuse dependency:</p> <p>(1) at least one staff member who is on duty shall be trained in alcohol and other drug withdrawal symptoms and symptoms of secondary complications to alcohol and other drug addiction; and</p> <p>(2) the services of a certified substance abuse counselor shall be available on an as-needed basis for each client.</p> <p>This Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure one of three clients (#3) treatment plan documented he was capable of remaining in the community without supervision. The findings are:</p> <p>Review on 5/3/19 of client #3's record revealed: - admitted to the facility 12/12/18</p>	V 290		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL064-148	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 06/05/2019
--	---	---	---

NAME OF PROVIDER OR SUPPLIER MOORE HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 3619 COOLEY LANE NASHVILLE, NC 27856
--	--

(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 290	<p>Continued From page 4</p> <ul style="list-style-type: none"> - diagnoses of Mood Disorder; Autism; Anxiety & Depression - a treatment plan dated 12/27/18 with no documentation of unsupervised time <p>Further review on 5/3/19 of client #3's treatment plan revealed:</p> <ul style="list-style-type: none"> - has no real concept of danger - will lie just to make friends - he does not do well in large groups - requires one on one attention because he will get lost <p>During interview on 6/5/19 a representative at the onsite job skill program reported:</p> <ul style="list-style-type: none"> - the job skill program was through Vocation Rehabilitation - 12 different areas of job skills were offered - the clients resided at a residential onsite campus with 24/7 staff - the program lasted 3 - 4 months depending on the client - every Thursday staff transported clients into the community - the clients are allowed to go in the community without staff (local mall...) - management at the job skill program encouraged clients to stay in groups when in the community <p>During interview on 6/5/19 the Licensee reported:</p> <ul style="list-style-type: none"> - client #3 resided at an onsite campus away from the facility - he attended the program that assisted with job skills - once he was admitted to the facility, the program made him aware he was accepted into the program - client #3 visited the facility on some weekends 	V 290		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL064-148	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 06/05/2019
--	---	---	---

NAME OF PROVIDER OR SUPPLIER MOORE HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 3619 COOLEY LANE NASHVILLE, NC 27856
--	--

(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 290	Continued From page 5 - she attended an orientation when client #3 was accepted the job skill program - she was under the impression the clients were supervised at all times - client #3 has Autism and does not do well without direction..."he will get lost" - she would follow up with the staff at the program	V 290		
V 776	27G .0304(d)(8) Same Sex Occupancy 10A NCAC 27G .0304 FACILITY DESIGN AND EQUIPMENT (d) Indoor space requirements: Facilities licensed prior to October 1, 1988 shall satisfy the minimum square footage requirements in effect at that time. Unless otherwise provided in these Rules, residential facilities licensed after October 1, 1988 shall meet the following indoor space requirements: (8) Only clients of the same sex may share a bedroom except for children age six or below, and married couples. This Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure same sex did not share the same bedroom for one of three clients (#3). The findings are: Review on 5/3/19 of client #1's record revealed: - admitted to the facility on 10/8/80 - diagnosis of Profound Intellectual Disability - a female client Review on 5/3/19 of client #2's record revealed: - admitted to the facility 6/14/11	V 776		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL064-148	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 06/05/2019
--	---	---	---

NAME OF PROVIDER OR SUPPLIER MOORE HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 3619 COOLEY LANE NASHVILLE, NC 27856
--	--

(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 776	<p>Continued From page 6</p> <ul style="list-style-type: none"> - diagnoses of Muscular Dystrophy & Hypertension - a male client <p>Review on 5/3/19 of client #3's record revealed:</p> <ul style="list-style-type: none"> - admitted to the facility 12/12/18 - diagnoses of Mood Disorder; Autism; Anxiety & Depression - a male client <p>Observation on 5/3/19 at 11:36am revealed:</p> <ul style="list-style-type: none"> - client #1 lying in her bed...not verbal enough to hold conversation - there was another bed in client #1's bedroom - client #2's bedroom was for a single person with only one bed observed <p>During interview on 5/3/19 client #2 reported:</p> <ul style="list-style-type: none"> - client #3 did not come to the facility much - when he came to the facility he slept on the couch <p>During interview on 5/3/19 the case management Qualified Professional reported:</p> <ul style="list-style-type: none"> - she has visited the facility twice since January 2019 - client #2 & #3 shared a bedroom - client #3 refuses to share a bedroom with client #2 - he wants his own bedroom - she does not like the facility client #3 slept on the couch - she would discuss with Licensee to have client #2 & #3 share a bedroom - she explained to client #3 he could be transferred to another Alternative Family Living facility <p>During interview on 6/5/19 the Licensee reported:</p> <ul style="list-style-type: none"> - client #3 resided at an onsite campus away 	V 776		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL064-148	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 06/05/2019
--	---	---	---

NAME OF PROVIDER OR SUPPLIER MOORE HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 3619 COOLEY LANE NASHVILLE, NC 27856
--	--

(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 776	Continued From page 7 from the facility - he attended a program that assisted with job skills - client #3 visited the facility on some weekends - he slept on a couch in the living room when he came to the facility - this was his choice	V 776		