STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL011-316	B. WING		06/1	10/2019
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	•	
ZILLICOA 85 ZILLICOA						
	I		LE, NC 2880			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRODE DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
V 000	INITIAL COMMENT	-S	V 000			
	on June 10, 2019. unsubstantiated (#N Deficiencies were c	plaint survey was completed The complaints were NC00152170, #NC00151088). ited. sed for the following service NC 27G .5600A Supervised				
V 440	Living for Adults wit	h Mental Illness.	V 440			
V 118	10A NCAC 27G .02 REQUIREMENTS (c) Medication admi (1) Prescription or ronly be administere order of a person and drugs. (2) Medications shacklients only when acclient's physician. (3) Medications, incadministered only bunlicensed persons pharmacist or other privileged to prepare (4) A Medication Adall drugs administer current. Medication recorded immediate MAR is to include the (A) client's name; (B) name, strength, (C) instructions for a (D) date and time the (E) name or initials drug. (5) Client requests the	inistration: non-prescription drugs shall d to a client on the written uthorized by law to prescribe all be self-administered by uthorized in writing by the aluding injections, shall be y licensed persons, or by trained by a registered nurse, a legally qualified person and a and administer medications. In ministration Record (MAR) of a de to each client must be kept a dely after administration. The	V 118			

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

(X6) DATE TITLE

(X3) DATE SURVEY COMPLETED							
/10/2019							
ZILLICOA 85 ZILLICOA							
(X5) COMPLETE DATE							

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STATE FORM 6899 ZN3P11 If continuation sheet 2 of 6

STATEMEN	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPI	E CONSTRUCTION	(X3) DATE	SURVEY
		IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		MHL011-316	B. WING		06/1	0/2019
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ZILLICO	Δ	85 ZILLIC	_			
ZILLIOO		ASHEVILI	LE, NC 2880	1		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	D BE	(X5) COMPLETE DATE
V 118	Continued From pa	ge 2	V 118			
	supplements under office was signed by	ine medications and the supervision of the nursing y the physician on 11/26/18.				
	Review on 5/13/19 of 3/2019-5/2019 MARs for Client #2 revealed: -Cetirizine not administered routinely until 5/5/19. It was ordered as a routine medication not a PRN					
	 (as needed). -Metformin not documented as administered for the 6:00PM dose on 3/15/19 and 3/26/19. -Staff were signing the MAR for routine medications as they observed the client take their 					
	medicationsStaff did not sign the MAR when observing the supplements. The MAR indicated "not given by the facility"The self-administration orders for both routine					
		pplements were the same.				
	she met weekly with	9 with Client #2 revealed that n a nurse to prepare her week. She was handed her administer her own				
	Observation on 5/13 medications for Clie -Energy Xtra, over t -B-Complex Plus, o	he counter.				
	-Admitted on 1/24/1 Schizoaffective Disc Generalized Anxiety Deficit Hyperactivity -Physician's order of one daily. -Physician's order of	/ Disorder, and Attention				

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STATE FORM 6899 ZN3P11 If continuation sheet 3 of 6

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL011-316	B. WING		06/1	0/2019
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
ZILLICO	Α.	85 ZILLIC ASHEVII I	OA _E, NC 2880	1		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPROFICE OF THE APPROPROPROPROPROPERT OF THE APPROPROPROPROPERT OF THE APPROPROPROPERT OF THE APPROPROPROPERT OF THE APPROPROPERT OF THE	D BE	(X5) COMPLETE DATE
V 118	Continued From pa	ge 3	V 118			
	#3 to self-administer routine medications and supplements under the supervision of the nursing office was signed by the physician.					
	Client #3 revealed: -Staff were signing medications as they medicationsStaff did not sign the supplements. The the facility"The self-administrate medications and sure linterview on 5/13/19 she met weekly with	the MAR for routine y observed the client take their ne MAR when observing the MAR indicated "not given by ation orders for both routine pplements were the same. 9 with Client #3 revealed that in a nurse to prepare her week. She was handed her				
	pill box daily to self-medications. Interviews on 5/15/7 (licensed practical range of the control of the contr	administer her own 19 and 5/22/19 with the LPN nurse) revealed: Client #2 was always routine (as needed). She thought it is a PRN. ain the missed documentation a medication it should always win supplements, without was the intent of the order but the form was not				
V 131	Verification) HCPR - Prior Employment EALTH CARE PERSONNEL	V 131			

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN	N OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING:		COIVIPL	LETED		
		MHL011-316	B. WING		06/1	0/2019
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
ZILLICO	Δ	85 ZILLIC				
			_E, NC 2880		Т	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
V 131	health care facility of health care facility of Personnel Registry	ealth care personnel into a or service, every employer at a shall access the Health Care and shall note each incident propriate business files.	V 131			
	Based on record re failed to ensure eac substantiated findin on the North Carolii	view and interview the facility ch staff member had no legs of abuse or neglect listed na Health Care Personnel rior to hire for 3 of 6 audited				
	Staff #1 revealed: -Hired on 10/30/18. -No Health Care Pe	of the personnel record for ersonnel Registry check or hire. HCPR completed on				
	Review on 5/15/19 Staff #2 revealed: -Date of hire was 10 -HCPR check cond					
	Staff #3 revealed: -Date of hire was 8, -No Health Care Pe	of the personnel record for /21/18. ersonnel Registry check o hire. HCPR completed on				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	MHL011-316	<u>l</u>		06/1	0/2019
NAME OF PROVIDER OR SUPPLIER	STREET ADI		STATE, ZIP CODE		
ZILLICOA		LE, NC 2880	1		
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
revealed: -The HCPR checks Staff #3. She was u	9 with the Senior Director were missed for Staff #1 and unaware of the oversight. e completed by the Human nent.	V 131			

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