STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					3) DATE SURVEY COMPLETED	
		mhl026-005	B. WING			R 12/2019
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	STATE, ZIP CODE	•	
MYROVE	R-REESE FELLOWS	HIP HOME	LITY ROAD VILLE, NC 2	28306		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
V 000	INITIAL COMMENT	ΓS	V 000			
	on 9/12/2019. Definition of 9/12/2019. Definition on 9/12/2019. Definition on 9/12/2019. Definition on 9/12/2019. Definition on 9/12/2019. Definition of 9/12/2019. Definit	w up survey was completed ciencies were cited. sed for the following service AC 27G .5600E Supervised h Substance Abuse.				
V 114	27G .0207 Emerge	ncy Plans and Supplies	V 114			
	AND SUPPLIES (a) A written fire pla area-wide disaster shall be approved be authority. (b) The plan shall be and evacuation pro posted in the facility (c) Fire and disaste shall be held at leas repeated for each se under conditions the	an for each facility and plan shall be developed and by the appropriate local e made available to all staff cedures and routes shall be ar drills in a 24-hour facility at quarterly and shall be shift. Drills shall be conducted at simulate fire emergencies.				
	failed to ensure fire	et as evidenced by: view and interview the facility and disaster drills were held nd repeated on each shift. The				
	2019 to September2018No third shift fire of	f facility records for August 2019 revealed: drill for the third quarter. drill for the fourth quarter.				

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

TITLE (X6) DATE

-	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		mhl026-00	5	B. WING			R 12/2019
NAME OF F	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MYROVE	R-REESE FELLOWS	HIP HOME		ITY ROAD	28306		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIEI ' MUST BE PRECEDEI SC IDENTIFYING INFO	D BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
V 114	Continued From pa	ge 1		V 114			
	- No third shift disas	ster drill for the fo	ourth quarter.				
	2019 - No third shift fire of No third shift fire of No third shift disast Interview on 9/9/19	Irill for the secon	d quarter. st quarter.				
	lived there since 9/4 in any drills						
	Interview on 9/9/19 were: -First shift 8a-2p - Second shift 2p-10 - Third shift 10p-6a		ed their shifts				
	Interview on 9/9/19 - They would do it She understood fit done quarterly and	re and disaster d	rills are to be				
V 118	27G .0209 (C) Med	ication Requirem	ents	V 118			
	10A NCAC 27G .02 REQUIREMENTS (c) Medication admi (1) Prescription or r only be administere order of a person addrugs. (2) Medications sha clients only when ad client's physician.	inistration: non-prescription of d to a client on the uthorized by law all be self-administ uthorized in writir	drugs shall ne written to prescribe stered by ng by the				
	(3) Medications, inc administered only b unlicensed persons pharmacist or other privileged to prepar	y licensed perso trained by a reg legally qualified	ns, or by stered nurse, person and				

Division of Health Service Regulation

STATE FORM 56899 Z0OQ11 If continuation sheet 2 of 16

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
					F		
		mhl026-005	B. WING		09/1	2/2019	
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
MYROVE	R-REESE FELLOWS	HIP HOME	ITY ROAD	9206			
(V4) ID	SHIMMADV STA	TEMENT OF DEFICIENCIES	VILLE, NC 2	PROVIDER'S PLAN OF CORRECTION)NI	(VE)	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE	
V 118	Continued From pa	ge 2	V 118				
	(4) A Medication Ad all drugs administer current. Medication recorded immediate MAR is to include the (A) client's name; (B) name, strength, (C) instructions for (D) date and time the (E) name or initials drug. (5) Client requests checks shall be recorded.	Iministration Record (MAR) of red to each client must be kept s administered shall be ely after administration. The					
	facility failed to adm written order of a pl MARs current affect clients (#'1, #3 and Review on 9/9/19 o - 30 year old female -Admission date of -Diagnoses of: Opio Depression.	views and interviews, the ninister medications on the hysician and failed to keep the ting three of three audited #6). The findings are: f Client #1's record revealed: 5/31/19. bid Use Disorder and					
	revealed: 7/24/19						

Division of Health Service Regulation

STATE FORM 5699 Z00Q11 If continuation sheet 3 of 16

	IT OF DEFICIENCIES		(V2) MULTIPL	E CONSTRUCTION	(X3) DATE	CLID\/EV
	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION		LETED
			A. DOILDING.		_	
		mhl026-005	B. WING		F 00/4	2/2019
		11111028-005			1 09/1	2/2019
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
MYROVE	R-REESE FELLOWS	HIP HOME	LITY ROAD			
			VILLE, NC 2	28306		T.
(X4) ID PREFIX		TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO		DATE
				DEFICIENCY)		
V 118	Continued From pa	ge 3	V 118			
		ligrams (mg) - 1 tablet daily.				
	8/29/19	sed to treat major depressive				
	disorder) 150mg - 1					
		eats vitamin D deficiency)				
	1000 units - 2 table	ts daily.				
	Review on 9/9/19 o	f Client # 1's August 2019 and				
	Review on 9/9/19 of Client # 1's August 2019 and September 2019 MAR's revealed the following					
	blanks:					
	August 2019					
		19, 8/16/19, and 8/25/19 at				
	2pm.					
	September 2019					
	- Bupropion - 9/2/19	and 9/6/19 at 6am and 2pm.				
	- Mavyret - 9/2/19 a					
		9 and 9/6/19 at 6am. 0/2/19 and 9/6/19 at 6am.				
	- Cholecalcherol - 8	72/19 and 9/0/19 at ban.				
	Review on 9/9/19 o	f Client #3's record revealed:				
	- 51 year old female					
	-Admission date of					
		phol Use Disorder-Severe, y Disorder, Neuropathy.				
	Ocheralized / trixiet	y Bisorder, redropatily.				
		f signed physician orders				
	revealed:					
	8/12/19 Gahanentin (used t	o treat nerve pain) 300mg - 1				
		times daily and 2 caps at				
	bedtime.					
	8/18/19					
		treat anxiety) 10mg - tablet				
	twice daily. 8/19/19					
		treat general anxiety				
	disorder) 20mg - 2					
	Review on 9/9/19 o	f Client # 3's August 2019 and				

Division of Health Service Regulation

STATE FORM 56899 Z0OQ11 If continuation sheet 4 of 16

Division	<u>of Health Service Re</u>	egulation					
	IT OF DEFICIENCIES OF CORRECTION		R/SUPPLIER/CLIA ATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY
		mhl026	6-00 5	B. WING		F 09/1	≷ 2/2019
NAME OF I	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MYROVE	R-REESE FELLOWS	HIP HOME	· ·	LITY ROAD VILLE, NC 2	8306		
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENCY REGULATORY OR L		EDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
V 118	Continued From pa	ge 4		V 118			
	September 2019 M blanks: August 2019 - Buspirone - 8/28/1 September 2019 - Gabapentin - 9/6/1 - Buspirone - 9/6/19 - Buspirone - 9/6/19 - Duloxetine - 9/6/19 - Duloxetine - 9/6/19 - Review on 9/9/19 o - 40 year old female - Admission date of - Diagnoses of: Coo Opioid use Disorde Review on 9/9/19 o revealed: 9/4/19 Lamictal (used to tr disorder) 150mg - 1 Review on 9/9/19 o MAR's revealed the - Lamictal - 9/6/19 a lnterview on 9/9/19 received her medications to her They had forgotter medications to take - Staff don't remind - Sometimes she m to go somewhere She had never ref	AR's reveale 19 at 6am. 19 at 6am. 19 at 6am. 9 and 9/7/19 at 6am. 19 at 6am. 10 at 6am. 11 at 6am. 12 at 6am. 13 at 6am. 14 at 6am. 15 at 6am. 16 client # 1 states of 6 at 6am. 17 at 6 at 6am. 18 at 6am. 19 at 6am. 19 at 6am. 19 at 6am. 10 at 6am. 10 at 6am. 11 at 6am. 12 at 6am. 13 at 6am. 14 at 6am. 15 at 6am. 16 at 6am. 17 at 6am. 18 at 6am. 19 at 6am. 10 at 6am. 10 at 6am. 10 at 6am. 11 at 6am. 12 at 6am. 13 at 6am. 14 at 6am. 15 at 6am. 16 at 6am. 17 at 6am. 18 at 6am. 19 at 6am. 10 at 6am. 10 at 6am. 10 at 6am. 11 at 6am. 12 at 6am. 13 at 6am. 14 at 6am. 15 at 6am. 16 at 6am. 17 at 6am. 18 at 6am. 19 at 6am. 19 at 6am. 10 at 6am. 11 at 6am. 12 at 6am. 13 at 6am. 14 at 6am. 15 at 6am. 16 at 6am. 17 at 6am. 18 at 6am. 18 at 6am. 19 at 6am. 10	at 6am. at 6am. record revealed: corder- Severe, sician orders and bipolar daily. September 2019 ank: ated she had ay as ordered. ted: er her the scheduled her medications. ication if staff had her medications.				
	Interview on 9/9/19	Client # 6 sta	ated she gets her				

medications as prescribed.

STATE FORM 6899 If continuation sheet 5 of 16 Z00Q11

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING: (X3)			
		mhl026-005	B. WING			R 12/2019
NAME OF I	PROVIDER OR SUPPLIER	STREE	T ADDRESS, CITY,	STATE, ZIP CODE		
MYROVE	ER-REESE FELLOWS	HIP HOME	UALITY ROAD			
		FAYE	TEVILLE, NC 2	I .		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
V 118	Continued From pa	ge 5	V 118			
V 133	- She checks their r swallowed the med - All staff had trainin administered. Due to the failure to medication adminis determined if client medications as order	take their medications. mouth to make sure they				
	CHECK REQUIRED APPLICANTS FOR (a) Definition As a "provider" applies to program and any prodevelopmental disaservices that is licer Chapter. (b) Requirement A provider licensed unapplicant to fill a position applicant to have an conditioned on conscriminal history receives the applicant has beliess than five years is conditioned on constrainal history receives the applicant has beliess than five years is conditioned on constrainal history receives the applicant has believed as the conditional criminal history receives the applicant has believed the		the from the land th			

PRINTED: 09/23/2019 FORM APPROVED

DIVISION	of Health Service Re	egulation		_			
	IT OF DEFICIENCIES		R/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFIC	ATION NUMBER:	A. BUILDING:		COMP	PLETED
						F	₹
		mhl026	S-005	B. WING			2/2019
				<u>I</u>		1 00/1	2,2010
NAME OF I	PROVIDER OR SUPPLIER			, ,	STATE, ZIP CODE		
MYROVE	R-REESE FELLOWS	HIP HOME		ITY ROAD			
			FAYETTE	VILLE, NC 2	8306		
(X4) ID		TEMENT OF DEF		ID	PROVIDER'S PLAN OF CORRECT		(X5)
PREFIX TAG	(EACH DEFICIENC) REGULATORY OR L			PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO		COMPLETE DATE
IAO				IAG	DEFICIENCY)		
1/400	0	0		1/400			
V 133	Continued From pa	ige 6		V 133			
	check of the applica	ant. A provide	er shall not				
	employ an applican	t who refuses	s to consent to a				
	criminal history rec						
	section. Except as	otherwise pro	ovided in this				
	subsection, within f						
	the conditional offe		· •				
	shall submit a requ						
	Justice under G.S.						
	criminal history rec						
	section or shall sub						
	entity to conduct a						
	check required by t						
	G.S. 114-19.10, the						
	return the results of						
	record checks for e						
	covered by Public L						
	Department of Hea						
	Criminal Records C						
	business days of re history of the perso						
	and Human Service						
	Unit, shall notify the						
	information receive						
	of the applicant. In						
	national criminal his						
	with the provider. P						
	upon request verific						
	check has been co		•				
	by this section. A co						
	appropriate local or						
	the Division of Crim						
	may conduct on be						
	criminal history rec						
	section without the	provider havi	ing to submit a				
	request to the Depa						
	case, the county sh						
	criminal history rec						
	section within five b						
	conditional offer of	employment	by the provider.				

6899

	PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
				F	3
	mhl026-005	B. WING			2/2019
NAME OF PROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, S	STATE, ZIP CODE		
MYROVER-REESE FELLOWSHIP H	IOME :	ITY ROAD			
	FAYETTE	/ILLE, NC 2	8306		
(X4) ID SUMMARY STATEMEN PREFIX (EACH DEFICIENCY MUST TAG REGULATORY OR LSC IDE	FBE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROINT DEFICIENCY)	D BE	(X5) COMPLETE DATE
V 133 Continued From page 7		V 133			
All criminal history inform provider is confidential at except to the applicant at (c) of this section. For pusubsection, the term "privibusiness regularly engage criminal history record chrecords obtained from a (c) Action If an applicant record check reveals one a relevant offense, the profithe following factors in hire the applicant: (1) The level and serious (2) The date of the crime (3) The age of the person conviction. (4) The circumstances sucommission of the crime (5) The nexus between the person and the job difilled. (6) The prison, jail, probate rehabilitation, and emploperson since the date the (7) The subsequent coma relevant offense. The fact of conviction of shall not be a bar to emplisted factors shall be corlifted may disclose information of the relevant offense may disclose information of the criminal history recorder may disclose information.	and may not be disclosed, as provided in subsection surposes of this vate entity" means a ged in conducting hecks utilizing public State agency. In the scriminal history error or more convictions of rovider shall consider all andetermining whether to senses of the crime. Even at the time of the urrounding the even in the position to be ation, parole, by ment records of the errime was committed. In the provider shall conduct of the even was committed. In the provider was a relevant offense alone ployment; however, the even insidered by the provider. It is an applicant after want factors, then the formation contained in the check that is relevant ut may not provide a copy cord check to the	V 155			

DIVISION	of Health Service Re	egulation					
	IT OF DEFICIENCIES		R/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFIC	ATION NUMBER:	A. BUILDING:		COMP	PLETED
						F	₹
		mhl020	6-005	B. WING			2/2019
NAME OF I	PROVIDER OR SUPPLIER	•	QTDEET AD	DDESS CITY S	STATE, ZIP CODE	-	
NAIVIL OF I	FROVIDER OR SUFFEIER			ITY ROAD	STATE, ZIF GODE		
MYROVE	R-REESE FELLOWS	HIP HOME		VILLE, NC 2	8306		
(X4) ID	SUMMARY STA	TEMENT OF DE		ID	PROVIDER'S PLAN OF CORRECT	ON	(X5)
PREFIX	(EACH DEFICIENCY			PREFIX	(EACH CORRECTIVE ACTION SHOU		COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING	SINFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO DEFICIENCY)	PRIATE	DATE
					DEI IOIEIVOT)		
V 133	Continued From pa	ge 8		V 133			
	complies with this section shall be immune from						
	civil liability for:						
	(1) The failure of the	e provider to	employ an				
	individual on the ba						
	the criminal history	record check	c of the individual.				
	(2) Failure to check						
	criminal offenses if						
	history record chec		d and received in				
	compliance with this section.						
	(e) Relevant Offens						
	"relevant offense" n						
	federal criminal hist						
	indictment of a crim felony, that bears u						
	have responsibility						
	persons needing m						
	disabilities, or subs						
	crimes include the						
	any of the following	Articles of C	hapter 14 of the				
	General Statutes: A	article 5, Cou	nterfeiting and				
	Issuing Monetary S						
	Endangering Execu						
	Article 6, Homicide;						
	Sex Offenses; Artic						
	Kidnapping and Abo						
	Injury or Damage b						
	Incendiary Device of and Other Housebr						
	Other Burnings; Art						
	Robbery; Article 18						
	False Pretenses an						
	Obtaining Property		•				
	Fraudulent Use of (•				
	Article 19B, Financi						
	Act; Article 20, Frau						
	26, Offenses Again						
	Decency; Article 26						
	Article 27, Prostituti						
	29 Bribery Article	31 Miscondi	ict in Public				

6899

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	,				SURVEY LETED
				A. BUILDING:			,
		mhl026-005	В	B. WING		09/1	2/2019
NAME OF	PROVIDER OR SUPPLIER	STRE	ET ADDR	RESS, CITY, S	STATE, ZIP CODE		
MYROVI	ER-REESE FELLOWS	HIP HOME		TY ROAD LLE, NC 2	8306		
240.15	CLIMMA DV CTA			-		ION	0/5)
(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 APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
V 133	Continued From pa	ge 9	,	V 133			
V 133	Office; Article 35, C Peace; Article 36A, Article 39, Protection Protection of the Fa Intoxication; and Ar Crime. These crime sale of drugs in violation Controlled Substan 90 of the General Soffenses such as saviolation of G.S. 18 impaired in violation G.S. 20-138.5. (f) Penalty for Furniapplicant for emplosupplies, or otherwan employment approximinal history recessful be guilty of a C (g) Conditional Employan applicant obtaining the result check regarding the following requirement (1) The provider shorion to obtaining the criminal history recessubsection (b) of the fingerprint cards as (2) The provider shoriminal history recessubsectional employing 2001-155, s. 1; 200	offenses Against the Public Riots and Civil Disorders; on of Minors; Article 40, amily; Article 59, Public ticle 60, Computer-Relatedes also include possession ation of the North Carolina ces Act, Article 5 of Chapte Statutes, and alcohol-relate ale to underage persons in B-302 or driving while of G.S. 20-138.1 through shing False Information yment who willfully furnished is gives false information olication that is the basis for check under this section Class A1 misdemeanor. Cloyment A provider may at conditionally prior to see applicant if both of the	Any es, on or a on	V 133			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		D·	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		mhl026-005		B. WING			≷ 2/2019
NAME OF F	PROVIDER OR SUPPLIER	ST	REET ADD	RESS, CITY, S	STATE, ZIP CODE		
MYROVE	R-REESE FELLOWS	HIP HOME		TY ROAD ILLE, NC 2	28306		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ITEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULI SC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
V 133	Continued From pa	ge 10		V 133			
	facility failed to requestes within five to for one of three aud are:	et as evidenced by: view and interviews, the uest state criminal backg business days of employi dited staff (#1). The finding	ground ment ngs				
	revealed: - Date of hire: 3/28/ - A countywide crim 3/25/19	·					
		staff #1 stated she had by since April 1, 2019.					
	was aware state cri were required and t	9 the former director stated in the state of	ks ate				
V 289	27G .5601 Supervis	sed Living - Scope		V 289			
	provides residential home environment these services is the rehabilitation of individuals, a developm or a substance abusupervision when ir (b) A supervised live the facility serves expression of the services of the servic	ng is a 24-hour facility what services to individuals in where the primary purpose care, habilitation or ividuals who have a mental disability or disability or disability or disability or the residence.	n a ose of ntal ities, quire				

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 1	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
				 	F	
		mhl026-005	B. WING		09/1	2/2019
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MVDOV	ER-REESE FELLOWS	LIB HOME 613 QUAL	LITY ROAD			
WITKOVE	IN-NEESET ELLOWS	FAYETTE	VILLE, NC 2	28306		
(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 APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
V 289	Continued From pa	ge 11	V 289			
	(2) two or mode Minor and adult clies ame facility. (c) Each supervise licensed to serve a designated below: (1) "A" design serves adults whos illness but may also (2) "B" design serves minors who developmental disadiagnoses; (3) "C" design serves adults whose developmental disadiagnoses; (4) "D" design serves adults whose developmental disadiagnoses; (4) "D" design serves minors who substance abused other diagnoses; (5) "E" design serves adults whose substance abused other diagnoses; (6) "F" design private residence, where adult clients whose primadevelopmental disabilities, or three clients whose primadevelopmental disabilities wh	ore adult clients. ents shall not reside in the ad living facility shall be specific population as mation means a facility which e primary diagnosis is mental o have other diagnoses; mation means a facility which se primary diagnosis is a ability but may also have other mation means a facility which e primary diagnosis is a ability but may also have other mation means a facility which se primary diagnosis is a ability but may also have other mation means a facility which se primary diagnosis is ependency but may also have mation means a facility which e primary diagnosis is ependency but may also have mation means a facility in a which serves no more than whose primary diagnoses is may also have other adult clients or three minor				

Division of Health Service Regulation

STATE FORM 56899 Z0OQ11 If continuation sheet 12 of 16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
				A. BOILDING.		F	,	
mhl026-005		B. WING			09/12/2019			
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
MYROVER-REESE FELLOWSHIP HOME 613 QUALIT FAYETTEVII					8306			
(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 CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE	
V 289	(a),(b); 10A NCAC 27G .0208 (b),(e); non-prescription m (1)(A),(D),(E);(f);(g) (b)(2),(d)(4). This is alternative family liv (AFL).	27G .0207 (b) 10A NCAC 27 edications only); and 10A NC facility shall als ving or assiste	G .0209[(c)(1) - y] (d)(2),(4); (e) AC 27G .0304 so be known as d family living	V 289				
	This Rule is not met as evidenced by: Based on record review, observation, and interview the facility failed to ensure it operated within the scope for which it was licensed. The findings are: Review on 9/9/19 of the facility's license showed it is licensed as a .5600E facility for supervised living for adults, with a capacity of 11, whose primary diagnosis is substance abuse dependency.							
	Review on 9/09/19 revealed: - FC #1 was not list	_						
	Review on 9/09/19 revealed: - Former Client (FC staff (PRN) with a h	c) #1 was a cu	rrent as needed					
	Observation on 9/0 of FC #1's bedroon - The client bedroo occupancy room at	n #4 revealed: m was identifi	ed as a single					
	Interview on 9/09/1 Home Manager sta		t Shift Group					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED			
mhl026-005		B. WING			R 09/12/2019			
NAME OF	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 613 QUALITY ROAD							
MYROVE	R-REESE FELLOWS	HIP HOME	· ·	VILLE, NC 2	8306			
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENCY REGULATORY OR L		ED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE	
V 289	Continued From pa	ge 13		V 289				
	- FC #1 had compl extended stay.	eted the progra	m and was					
	Interview on 9/12/19 with the Director stated FC#1 is extended stay with the facility and she understood that only clients receiving treatment can remain in a licensed bed.							
V 290	290 27G .5602 Supervised Living - Staff			V 290				
	abuse disorders shof one staff present clients present. Ho present during slee emergency back-up the governing body	in Paragraphs (determined by ond to individual one staff member when any adult hen the client's cuments that the gin the home of the capable	b), (c) and (d) the facility to alized client er shall be client is on the treatment or e client is or community Il be reviewed Illy to ensure of remaining in pervision for ty in the ore than one t: with substance ith a minimum or fewer minor e staff need be etermined by with served with					

6899

Division of Health Service Regulation						
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
		A. BUILDING:		COMPLETED		
					F	۱
		mhl026-005	B. WING			` 2/2019
			1		, 00/1	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MYROVE	R-REESE FELLOWS	HIP HOME 613 QUAL	LITY ROAD			
WITHOUL	IN-NELOE I ELLOWO	FAYETTE	VILLE, NC 2	28306		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON	(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			(EACH CORRECTIVE ACTION SHOUL		COMPLETE DATE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROI	PRIAIE	DAIL
V 290	Continued From pa	ige 14	V 290			
	nresent and two sta	aff present for every four or				
		nt. However, only one staff				
		ring sleeping hours if				
		ergency back-up procedures				
	determined by the					
		ch serve clients whose primary				
		nce abuse dependency:				
	(1) at least or	ne staff member who is on				
		d in alcohol and other drug				
		ns and symptoms of				
		ations to alcohol and other				
	drug addiction; and					
	· /	es of a certified substance				
		nall be available on an				
	as-needed basis for each client.					
	This Rule is not me	et as evidenced by:				
	Based on record review and interview the facility failed to ensure that at least one staff member on duty was trained in alcohol and other drug withdrawal symptoms for 1 of 3 audited staff (#1).					
	The findings are:	,				
	Review on 9/9/19 Staff #1's personnel record revealed: - Hire date of 3/29/19 No documentation of training on alcohol and					
	drug withdrawal syr	nptoms.				
		0				
	Interview on 9/9/19 with Staff #1 stated:					
	- She had not received any formal training on alcohol and drug withdrawal symptoms.					
	alconol and drug wi	ımarawar symptoms.				
	Interview on 0/0/10	with the Former Director				
	Interview on 9/9/19 with the Former Director stated: - He is aware Staff #1 had not received any					
		lcohol and drug withdrawal				
	Torrida danning on a	assistant and withdrawar				

Division of Health Service Regulation

STATE FORM 5699 Z00Q11 If continuation sheet 15 of 16

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	(X3) DATE SURVEY COMPLETED	
		B. WING			R	
		mhl026-005	D. WING		09/1	2/2019
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
MYROVE	R-REESE FELLOWS	HIP HOME	LITY ROAD VILLE, NC 2	28306		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
V 290	symptoms They have planne	ge 15 d a training to educate staff on thdrawal symptoms.	V 290			