

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL026-214</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>09/12/2019</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>ASHTON W LILLY HOME</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>560 WILKES ROAD</b> <b>FAYETTEVILLE, NC 28306</b>
--	--

(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><b>INITIAL COMMENTS</b></p> <p>An annual and follow up survey was completed on September 12, 2019. Deficiencies were cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .5600E Supervised Living for Adults with Substance Abuse.</p>	V 000		
V 108	<p><b>27G .0202 (F-I) Personnel Requirements</b></p> <p><b>10A NCAC 27G .0202 PERSONNEL REQUIREMENTS</b></p> <p>(f) Continuing education shall be documented.</p> <p>(g) Employee training programs shall be provided and, at a minimum, shall consist of the following:</p> <p>(1) general organizational orientation;</p> <p>(2) training on client rights and confidentiality as delineated in 10A NCAC 27C, 27D, 27E, 27F and 10A NCAC 26B;</p> <p>(3) training to meet the mh/dd/sa needs of the client as specified in the treatment/habilitation plan; and</p> <p>(4) training in infectious diseases and bloodborne pathogens.</p> <p>(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.</p> <p>(i) The governing body shall develop and implement policies and procedures for identifying, reporting, investigating and controlling infectious and communicable diseases of personnel and</p>	V 108		

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:  <b>MHL026-214</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>09/12/2019</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>ASHTON W LILLY HOME</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>560 WILKES ROAD</b> <b>FAYETTEVILLE, NC 28306</b>
--	--

(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 108	<p>Continued From page 1</p> <p>clients.</p> <p>This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure Diabetes training for 2 of 3 audited staff (Staff #2 and #3). The findings are:</p> <p>Review on 9/11/19 of client #5's record revealed:</p> <ul style="list-style-type: none"> <li>- 63 year old male.</li> <li>- Admission date of 7/02/19.</li> <li>- Diagnoses of Alcohol Dependence, Cocaine Dependence, Diabetes Mellitus, Hypertension, Hyperlipidemia, Sleep Apnea and Allergies.</li> </ul> <p>Review on 9/12/19 of Staff #2's personnel record revealed:</p> <ul style="list-style-type: none"> <li>- Date of Hire on 10/3/18.</li> <li>- No documentation of diabetes training.</li> </ul> <p>Interview on 9/11/19 Staff #2 stated:</p> <ul style="list-style-type: none"> <li>- He was aware Client #5 had diabetes</li> <li>- He did not have training in diabetes.</li> </ul> <p>Review on 9/11/19 of Staff #3's personnel record revealed:</p> <ul style="list-style-type: none"> <li>- Date of hire on 3/21/19.</li> <li>- No documentation of diabetes training.</li> </ul> <p>Interview on 9/11/19 Staff #3 stated:</p> <ul style="list-style-type: none"> <li>- Residents receive same diets.</li> <li>- He did not have any training on diabetes.</li> </ul> <p>Interview on 9/11/19 the Clinical Coordinator stated:</p> <ul style="list-style-type: none"> <li>- Client #5's local medical center had staff that talked with the facility cook (Staff #3) about diet</li> </ul>	V 108		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL026-214</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>09/12/2019</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>ASHTON W LILLY HOME</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>560 WILKES ROAD</b> <b>FAYETTEVILLE, NC 28306</b>
--	--

(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 108	Continued From page 2  restrictions and cooking without seasonings. - Cook was to develop menus. - She's not sure if menus were developed.  Interview on 9/12/19 the Director stated: -They have trainings planned and will follow up to ensure all staff are trained.  This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 108		
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		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL026-214</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>09/12/2019</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>ASHTON W LILLY HOME</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>560 WILKES ROAD</b> <b>FAYETTEVILLE, NC 28306</b>
--	--

(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 112	<p>Continued From page 3</p> <p>This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to develop and implement strategies based on assessment for one of three audited clients (#5). The findings are:</p> <p>Review on 9/11/19 of Client #5's record revealed:</p> <ul style="list-style-type: none"> <li>- 63 year old male.</li> <li>- Admission date of 7/2/19.</li> <li>- Diagnoses of Alcohol Dependence, Cocaine Dependence, Diabetes Mellitus, Hypertension, Hyperlipidemia, Sleep Apnea and Allergies.</li> <li>- Treatment plan dated 7/2/19.</li> <li>- The Treatment Plan did not contain any strategies for his diagnosis of Diabetes and his specialized diet needs.</li> </ul> <p>Review on 9/11/19 of a discharge progress note from the local Veterans Administration (VA) hospital dated 7/1/19 revealed:</p> <ul style="list-style-type: none"> <li>- Heart Health Diet.</li> <li>- Diabetes Diet.</li> <li>- No added salt diet.</li> </ul> <p>Interview on 9/11/19 Staff #2 stated:</p> <ul style="list-style-type: none"> <li>- He was aware Client #5 had diabetes</li> <li>- He did not have training in diabetes.</li> </ul> <p>Interview on 9/11/19 Staff #3 stated:</p> <ul style="list-style-type: none"> <li>- Residents receive same diets.</li> <li>- He did not have any training on diabetes.</li> </ul> <p>Interview on 9/12/19 the Clinical Coordinator stated:</p> <ul style="list-style-type: none"> <li>- She is aware of client #5's diagnosis of</li> </ul>	V 112		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL026-214</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  R <b>09/12/2019</b>
--	---	---	--

NAME OF PROVIDER OR SUPPLIER  <b>ASHTON W LILLY HOME</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>560 WILKES ROAD FAYETTEVILLE, NC 28306</b>
--	--

(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 112	Continued From page 4  diabetes. - They did not have to have a list of certain foods for client #5 to eat and they did not have to tell client #5 what to eat. - Client #5 had dietary restrictions based on medication put into his treatment plan. - Client #5 was educated at the VA about his dietary restrictions. - She is aware that staff need strategies in the treatment plan in order to address client #5's diabetes and the treatment plan will be reviewed.	V 112		
V 118	27G .0209 (C) Medication Requirements  10A NCAC 27G .0209 MEDICATION REQUIREMENTS (c) Medication administration: (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. (2) Medications shall be self-administered by clients only when authorized in writing by the client's physician. (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. (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: (A) client's name; (B) name, strength, and quantity of the drug; (C) instructions for administering the drug; (D) date and time the drug is administered; and (E) name or initials of person administering the	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL026-214</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>09/12/2019</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>ASHTON W LILLY HOME</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>560 WILKES ROAD</b> <b>FAYETTEVILLE, NC 28306</b>
--	--

(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 5</p> <p>drug. (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> <p>This Rule is not met as evidenced by: Based on record reviews, observation and interviews, the facility failed to administer medications on the written order of a physician and failed to keep the MARs current affecting one of three current clients (#5). The findings are:</p> <p>Review on 9/11/19 of client #5's record revealed: - 63 year old male. - Admission date of 7/02/19. - Diagnoses of Alcohol Dependence, Cocaine Dependence, Diabetes Mellitus, Hypertension, Hyperlipidemia, Sleep Apnea and Allergies.</p> <p>Review on 9/11/19 of an electronically signed physician order for client #5 dated 07/30/19 revealed: - Blood Glucose test strips to check Finger Stick Blood Sugar (FSBS) values every other day. - Terbinafine 1% (anti-fungal medication) - apply a small amount twice daily. - Multivitamin (treats vitamin deficiency) - one tablet daily.</p> <p>Review on 9/11/19 of client #5's July 2019, August 2019 and September 2019 MAR's revealed: - No documented FSBS values. - No transcribed entry for Multivitamin and Terbinafine.</p>	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL026-214</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>09/12/2019</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>ASHTON W LILLY HOME</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>560 WILKES ROAD</b> <b>FAYETTEVILLE, NC 28306</b>
--	--

(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 6</p> <p>Observation on 9/11/19 at approximately 11:00am of client #5's medications revealed:</p> <ul style="list-style-type: none"> <li>- No multivitamin available for administration.</li> <li>- Terbinafine 1% with directions to apply twice daily.</li> </ul> <p>Interview on 9/11/19 client #5 stated:</p> <ul style="list-style-type: none"> <li>- He was admitted to the facility in July 2019 from the Veterans Administration (VA).</li> <li>- He had been diagnosed with Diabetes 5 or 6 years ago.</li> <li>- He had lost his glucometer before his admission to the facility.</li> <li>- The VA was supposed to send him a glucometer and it never came. He had to have another glucometer ordered.</li> <li>- He had just received his glucometer from the VA.</li> <li>- He was supposed to check his FSBS every other day. The last time he checked his blood sugar value it was within normal limits.</li> <li>- He went to the VA often and they checked his blood work.</li> <li>- He received his medications daily.</li> </ul> <p>Interview on 9/11/19 staff #1 stated:</p> <ul style="list-style-type: none"> <li>- He had worked at the facility for several years.</li> <li>- Client #5 was admitted under a VA contract.</li> <li>- The facility had difficulty at times getting medications and supplies from the VA.</li> <li>- He would make sure all ordered medications were administered as ordered and transcribed on the MARs.</li> <li>- Client #5 was at the VA today to ensure medications were received.</li> </ul> <p>Due to the failure to accurately document medication administration it could not be determined if client #5 received his medications</p>	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL026-214</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>09/12/2019</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>ASHTON W LILLY HOME</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>560 WILKES ROAD</b> <b>FAYETTEVILLE, NC 28306</b>
--	--

(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	Continued From page 7 as ordered by the physician.	V 118		
V 133	G.S. 122C-80 Criminal History Record Check  G.S. §122C-80 CRIMINAL HISTORY RECORD CHECK REQUIRED FOR CERTAIN APPLICANTS FOR EMPLOYMENT. (a) Definition. - As used in this section, the term "provider" applies to an area authority/county program and any provider of mental health, developmental disability, and substance abuse services that is licensable under Article 2 of this Chapter. (b) Requirement. - An offer of employment by a provider licensed under this Chapter to an applicant to fill a position that does not require the applicant to have an occupational license is conditioned on consent to a State and national criminal history record check of the applicant. If the applicant has been a resident of this State for less than five years, then the offer of employment is conditioned on consent to a State and national criminal history record check of the applicant. The national criminal history record check shall include a check of the applicant's fingerprints. If the applicant has been a resident of this State for five years or more, then the offer is conditioned on consent to a State criminal history record check of the applicant. A provider shall not employ an applicant who refuses to consent to a criminal history record check required by this section. Except as otherwise provided in this subsection, within five business days of making the conditional offer of employment, a provider shall submit a request to the Department of Justice under G.S. 114-19.10 to conduct a criminal history record check required by this section or shall submit a request to a private entity to conduct a State criminal history record	V 133		



Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL026-214</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>09/12/2019</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>ASHTON W LILLY HOME</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>560 WILKES ROAD</b> <b>FAYETTEVILLE, NC 28306</b>
--	--

(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 133	<p>Continued From page 8</p> <p>check required by this section. Notwithstanding G.S. 114-19.10, the Department of Justice shall return the results of national criminal history record checks for employment positions not covered by Public Law 105-277 to the Department of Health and Human Services, Criminal Records Check Unit. Within five business days of receipt of the national criminal history of the person, the Department of Health and Human Services, Criminal Records Check Unit, shall notify the provider as to whether the information received may affect the employability of the applicant. In no case shall the results of the national criminal history record check be shared with the provider. Providers shall make available upon request verification that a criminal history check has been completed on any staff covered by this section. A county that has adopted an appropriate local ordinance and has access to the Division of Criminal Information data bank may conduct on behalf of a provider a State criminal history record check required by this section without the provider having to submit a request to the Department of Justice. In such a case, the county shall commence with the State criminal history record check required by this section within five business days of the conditional offer of employment by the provider. All criminal history information received by the provider is confidential and may not be disclosed, except to the applicant as provided in subsection (c) of this section. For purposes of this subsection, the term "private entity" means a business regularly engaged in conducting criminal history record checks utilizing public records obtained from a State agency.</p> <p>(c) Action. - If an applicant's criminal history record check reveals one or more convictions of a relevant offense, the provider shall consider all</p>	V 133		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL026-214</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>09/12/2019</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>ASHTON W LILLY HOME</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>560 WILKES ROAD</b> <b>FAYETTEVILLE, NC 28306</b>
--	--

(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 133	<p>Continued From page 9</p> <p>of the following factors in determining whether to hire the applicant:</p> <ol style="list-style-type: none"> <li>(1) The level and seriousness of the crime.</li> <li>(2) The date of the crime.</li> <li>(3) The age of the person at the time of the conviction.</li> <li>(4) The circumstances surrounding the commission of the crime, if known.</li> <li>(5) The nexus between the criminal conduct of the person and the job duties of the position to be filled.</li> <li>(6) The prison, jail, probation, parole, rehabilitation, and employment records of the person since the date the crime was committed.</li> <li>(7) The subsequent commission by the person of a relevant offense.</li> </ol> <p>The fact of conviction of a relevant offense alone shall not be a bar to employment; however, the listed factors shall be considered by the provider. If the provider disqualifies an applicant after consideration of the relevant factors, then the provider may disclose information contained in the criminal history record check that is relevant to the disqualification, but may not provide a copy of the criminal history record check to the applicant.</p> <p>(d) Limited Immunity. - A provider and an officer or employee of a provider that, in good faith, complies with this section shall be immune from civil liability for:</p> <ol style="list-style-type: none"> <li>(1) The failure of the provider to employ an individual on the basis of information provided in the criminal history record check of the individual.</li> <li>(2) Failure to check an employee's history of criminal offenses if the employee's criminal history record check is requested and received in compliance with this section.</li> </ol> <p>(e) Relevant Offense. - As used in this section, "relevant offense" means a county, state, or</p>	V 133		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL026-214</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>09/12/2019</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>ASHTON W LILLY HOME</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>560 WILKES ROAD</b> <b>FAYETTEVILLE, NC 28306</b>
--	--

(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 133	Continued From page 10  federal criminal history of conviction or pending indictment of a crime, whether a misdemeanor or felony, that bears upon an individual's fitness to have responsibility for the safety and well-being of persons needing mental health, developmental disabilities, or substance abuse services. These crimes include the criminal offenses set forth in any of the following Articles of Chapter 14 of the General Statutes: Article 5, Counterfeiting and Issuing Monetary Substitutes; Article 5A, Endangering Executive and Legislative Officers; Article 6, Homicide; Article 7A, Rape and Other Sex Offenses; Article 8, Assaults; Article 10, Kidnapping and Abduction; Article 13, Malicious Injury or Damage by Use of Explosive or Incendiary Device or Material; Article 14, Burglary and Other Housebreakings; Article 15, Arson and Other Burnings; Article 16, Larceny; Article 17, Robbery; Article 18, Embezzlement; Article 19, False Pretenses and Cheats; Article 19A, Obtaining Property or Services by False or Fraudulent Use of Credit Device or Other Means; Article 19B, Financial Transaction Card Crime Act; Article 20, Frauds; Article 21, Forgery; Article 26, Offenses Against Public Morality and Decency; Article 26A, Adult Establishments; Article 27, Prostitution; Article 28, Perjury; Article 29, Bribery; Article 31, Misconduct in Public Office; Article 35, Offenses Against the Public Peace; Article 36A, Riots and Civil Disorders; Article 39, Protection of Minors; Article 40, Protection of the Family; Article 59, Public Intoxication; and Article 60, Computer-Related Crime. These crimes also include possession or sale of drugs in violation of the North Carolina Controlled Substances Act, Article 5 of Chapter 90 of the General Statutes, and alcohol-related offenses such as sale to underage persons in violation of G.S. 18B-302 or driving while	V 133		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL026-214</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>09/12/2019</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>ASHTON W LILLY HOME</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>560 WILKES ROAD</b> <b>FAYETTEVILLE, NC 28306</b>
--	--

(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 133	<p>Continued From page 11</p> <p>impaired in violation of G.S. 20-138.1 through G.S. 20-138.5.</p> <p>(f) Penalty for Furnishing False Information. - Any applicant for employment who willfully furnishes, supplies, or otherwise gives false information on an employment application that is the basis for a criminal history record check under this section shall be guilty of a Class A1 misdemeanor.</p> <p>(g) Conditional Employment. - A provider may employ an applicant conditionally prior to obtaining the results of a criminal history record check regarding the applicant if both of the following requirements are met:</p> <p>(1) The provider shall not employ an applicant prior to obtaining the applicant's consent for criminal history record check as required in subsection (b) of this section or the completed fingerprint cards as required in G.S. 114-19.10.</p> <p>(2) The provider shall submit the request for a criminal history record check not later than five business days after the individual begins conditional employment. (2000-154, s. 4; 2001-155, s. 1; 2004-124, ss. 10.19D(c), (h); 2005-4, ss. 1, 2, 3, 4, 5(a); 2007-444, s. 3.)</p> <p>This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to request state criminal background checks within five business days of employment for one of three audited staff (#3). The findings are:</p> <p>Review on 9/11/19 of staff #3's personnel record revealed: - Date of hire: 3/21/19.</p>	V 133		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL026-214</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>09/12/2019</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>ASHTON W LILLY HOME</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>560 WILKES ROAD</b> <b>FAYETTEVILLE, NC 28306</b>
--	--

(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 133	Continued From page 12  - No statewide criminal background check.  Interview on 9/11/19 staff #3 stated he had worked at the facility for about 5 months.  Interview on 9/11/19 the Former Director stated he was aware state criminal background checks were required and that they normally do State Bureau of Investigation (SBI) checks for their employees.	V 133		
V 289	27G .5601 Supervised Living - Scope  10A NCAC 27G .5601 SCOPE (a) Supervised living is a 24-hour facility which provides residential services to individuals in a home environment where the primary purpose of these services is the care, habilitation or rehabilitation of individuals who have a mental illness, a developmental disability or disabilities, or a substance abuse disorder, and who require supervision when in the residence. (b) A supervised living facility shall be licensed if the facility serves either: (1) one or more minor clients; or (2) two or more adult clients. Minor and adult clients shall not reside in the same facility. (c) Each supervised living facility shall be licensed to serve a specific population as designated below: (1) "A" designation means a facility which serves adults whose primary diagnosis is mental illness but may also have other diagnoses; (2) "B" designation means a facility which serves minors whose primary diagnosis is a developmental disability but may also have other diagnoses; (3) "C" designation means a facility which	V 289		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL026-214</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>09/12/2019</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>ASHTON W LILLY HOME</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>560 WILKES ROAD</b> <b>FAYETTEVILLE, NC 28306</b>
--	--

(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 289	<p>Continued From page 13</p> <p>serves adults whose primary diagnosis is a developmental disability but may also have other diagnoses;</p> <p>(4) "D" designation means a facility which serves minors whose primary diagnosis is substance abuse dependency but may also have other diagnoses;</p> <p>(5) "E" designation means a facility which serves adults whose primary diagnosis is substance abuse dependency but may also have other diagnoses; or</p> <p>(6) "F" designation means a facility in a private residence, which serves no more than three adult clients whose primary diagnoses is mental illness but may also have other disabilities, or three adult clients or three minor clients whose primary diagnoses is developmental disabilities but may also have other disabilities who live with a family and the family provides the service. This facility shall be exempt from the following rules: 10A NCAC 27G .0201 (a)(1),(2),(3),(4),(5)(A)&amp;(B); (6); (7) (A),(B),(E),(F),(G),(H); (8); (11); (13); (15); (16); (18) and (b); 10A NCAC 27G .0202(a),(d),(g)(1) (i); 10A NCAC 27G .0203; 10A NCAC 27G .0205 (a),(b); 10A NCAC 27G .0207 (b),(c); 10A NCAC 27G .0208 (b),(e); 10A NCAC 27G .0209[(c)(1) - non-prescription medications only] (d)(2),(4); (e) (1)(A),(D),(E);(f);(g); and 10A NCAC 27G .0304 (b)(2),(d)(4). This facility shall also be known as alternative family living or assisted family living (AFL).</p> <p>This Rule is not met as evidenced by: Based on record review, observation, and interview the facility failed to ensure it operated</p>	V 289		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL026-214</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>09/12/2019</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>ASHTON W LILLY HOME</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>560 WILKES ROAD</b> <b>FAYETTEVILLE, NC 28306</b>
--	--

(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 289	<p>Continued From page 14</p> <p>within the scope for which it was licensed. The findings are:</p> <p>Review on 9/12/19 of the facility's license showed it is licensed as a .5600E facility for supervised living for adults with a capacity of 16 whose primary diagnosis is substance abuse dependency.</p> <p>Review on 9/12/19 of the facility's client roster revealed:</p> <ul style="list-style-type: none"> <li>- Staff #3 was not listed as a current client nor a discharged client.</li> </ul> <p>Review on 9/12/19 of the facility's staff roster revealed:</p> <ul style="list-style-type: none"> <li>- Staff #3 was the cook for the facility with a hire date of 3/21/19.</li> </ul> <p>Observation on 9/11/19 at approximately 10:00am of Room #2 revealed:</p> <ul style="list-style-type: none"> <li>- The client bedroom was a single occupancy room at time of observation.</li> </ul> <p>Interview on 9/11/19 with Staff #3 stated:</p> <ul style="list-style-type: none"> <li>- He has been employed as the cook for about 5 months.</li> <li>- He currently resides in room #2.</li> <li>- He finished the program but did not feel he was ready to move on.</li> <li>- He pays the facility \$50.00 per week for rent.</li> </ul> <p>Interview on 9/11/19 with the First Shift Group Home Manager stated:</p> <ul style="list-style-type: none"> <li>- Staff #3 had completed the program and was extended stay.</li> <li>- Room #2 is Staff #3's bedroom.</li> <li>- Staff #3 graduated the program and pays rent.</li> </ul> <p>Interview on 9/11/19 the Director stated Staff #3 is</p>	V 289		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL026-214</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>09/12/2019</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>ASHTON W LILLY HOME</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>560 WILKES ROAD</b> <b>FAYETTEVILLE, NC 28306</b>
--	--

(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 289	Continued From page 15  extended stay with the facility and she understood that only clients receiving treatment can reside in a licensed bed.	V 289		
V 290	27G .5602 Supervised Living - Staff  10A NCAC 27G .5602 STAFF (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. (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. (c) Staff shall be present in a facility in the following client-staff ratios when more than one child or adolescent client is present: (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 (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	V 290		



Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL026-214</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>09/12/2019</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>ASHTON W LILLY HOME</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>560 WILKES ROAD</b> <b>FAYETTEVILLE, NC 28306</b>
--	--

(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 16</p> <p>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 that at least one staff member on duty was trained in alcohol and other drug withdrawal symptoms for 2 of 3 audited staff (#2 and #3). The findings are:</p> <p>Review on 9/12/19 of staff #2's personnel record revealed: - Re-hire date of 10/3/18 - No documentation of training on alcohol and drug withdrawal symptoms.</p> <p>Interview on 9/11/19 Staff #2 stated: - He did not have any training on alcohol and drug withdrawal symptoms.</p> <p>Review on 9/12/19 of Staff #3's personnel record revealed: - Hire date of 3/21/19. - No documentation of training on alcohol and drug withdrawal symptoms.</p> <p>Interview on 9/11/19 with Staff #3 stated: - He had not received any trainings.</p>	V 290		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL026-214</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>09/12/2019</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>ASHTON W LILLY HOME</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>560 WILKES ROAD</b> <b>FAYETTEVILLE, NC 28306</b>
--	--

(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 17  Interview on 9/12/19 with the Former Director stated: - He is aware Staff #2 and #3 had not received any formal training on alcohol and drug withdrawal symptoms. - They have planned a training to educate staff on alcohol and drug withdrawal symptoms.	V 290		
V 752	27G .0304(b)(4) Hot Water Temperatures  10A NCAC 27G .0304 FACILITY DESIGN AND EQUIPMENT (b) Safety: Each facility shall be designed, constructed and equipped in a manner that ensures the physical safety of clients, staff and visitors. (4) In areas of the facility where clients are exposed to hot water, the temperature of the water shall be maintained between 100-116 degrees Fahrenheit.  This Rule is not met as evidenced by: Based on observation and interview, the facility water temperatures were not maintained between 100-116 degrees Fahrenheit in areas where clients were exposed to hot water. The findings are:  Observations on 9/11/19 at approximately 9:46am revealed: - the shared hall bathroom to the left side of the building had a double sink and the temperature for both read 140 degrees Fahrenheit, 1 bath tub where the water temperature read 140 degrees Fahrenheit and 1 shower where the water temperature read 140 degrees Fahrenheit.	V 752		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL026-214</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>09/12/2019</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>ASHTON W LILLY HOME</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>560 WILKES ROAD</b> <b>FAYETTEVILLE, NC 28306</b>
--	--

(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 752	<p>Continued From page 18</p> <p>Interviews on 9/11/19 with Clients #1, #3, #4 and #5 revealed that they did not have any issues with the water temperature and were able to adjust the water on their own.</p> <p>Interview on 9/12/19 the Former Director stated: -He is aware the water temperature needs to be between 100-116 degrees Fahrenheit. He will follow up on the water temperature and that the local health department wants the water to be hotter than 116 degrees Fahrenheit.</p>	V 752		