STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL046-033	A. BUILDING: _____ B. WING _____	10/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHOANOKE VALLEY	1321 WEST FIRST STREET AHOSKIE, NC 27910

(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	INITIAL COMMENTS An annual and complaint survey was completed 10/8/19. The complaint was unsubstantiated Intake # NC00156237. Deficiencies were cited. This facility is licensed for the following service categories: 10A NCAC 27G .2300 Adult Developmental Vocational Program and 10A NCAC 27G .5400 Day Activity.	V 000		
V 108	27G .0202 (F-I) Personnel Requirements 10A NCAC 27G .0202 PERSONNEL REQUIREMENTS (f) Continuing education shall be documented. (g) Employee training programs shall be provided and, at a minimum, shall consist of the following: (1) general organizational orientation; (2) training on client rights and confidentiality as delineated in 10A NCAC 27C, 27D, 27E, 27F and 10A NCAC 26B; (3) training to meet the mh/dd/sa needs of the client as specified in the treatment/habilitation plan; and (4) training in infectious diseases and bloodborne pathogens. (h) Except as permitted under 10a NCAC 27G .5602(b) of this Subchapter, at least one staff member shall be available in the facility at all times when a client is present. That staff member shall be trained in basic first aid including seizure management, currently trained to provide cardiopulmonary resuscitation and trained in the Heimlich maneuver or other first aid techniques such as those provided by Red Cross, the American Heart Association or their equivalence for relieving airway obstruction. (i) The governing body shall develop and implement policies and procedures for identifying,	V 108		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL046-033	A. BUILDING: _____ B. WING _____	10/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHOANOKE VALLEY	1321 WEST FIRST STREET AHOSKIE, NC 27910

(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 1 reporting, investigating and controlling infectious and communicable diseases of personnel and clients. This Rule is not met as evidenced by: Based on observation, record review and interviews, the governing body failed to ensure training programs were provided to meet the needs of the population served for 3 of 6 current audited staff (Day Activity Director; staff #2; staff #3) and 1 of 1 former staff (FS#5). The findings are: Review on 9/26/19 and 10/1/19 of client #11's record revealed: - admitted 3/7/14 - diagnoses of Autism with language impairment and Intellectual Development Disorder (IDD) Review on 9/26/19 of Day Activity Director's personnel record revealed: - a hire date of 5/2/13 - no evidence of training in Autism Review on 9/26/19 of staff #2's personnel record revealed: - a hire date of 12/3/18 - no evidence of training in Autism Review on 9/26/19 of staff #3's personnel record revealed: - a hire date of 12/18/17 - no evidence of training in Autism Review on 9/26/19 of Former Staff (FS#5)'s	V 108		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL046-033	A. BUILDING: _____ B. WING _____	10/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHOANOKE VALLEY	1321 WEST FIRST STREET AHOSKIE, NC 27910

(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	V 108		

personnel record revealed
- a hire date of 3/25/19
- no documentation of last day of services by FS#5
- no evidence of training in Autism

During interview on 10/1/19 the QP reported:
- she was the QP since 2014 or 2015
- client specific training was done yearly including Autism
- she would fax staff training

Review on 10/2/19 of a fax dated 10/2/19 to the Department of Health Service Regulation (DHSR) revealed:
- a staff training sign in sheet dated 6/11/19
- training in Autism provided by the facility's QP
- the Day Activity Director's name was not listed on the sign in sheet

Review on 9/26/19, 10/1/19 and 10/8/19 of Incident Reporting Improvement System (IRIS) report, General Event reports and Quality Assurance Committee notes revealed multiple incidents involving client #11 displaying aggression towards peers. The reports revealed:
- 1/8/19, client #11 hit client #18 with a closed fist after she asked for a pencil; no injuries noted
- 2/27/19, client #11 hit client #15 hard with a closed fist when he walked passed client #15 to get his lunch bag; client #11 showed no remorse when confronted; no injuries noted
- 5/9/19, client #11 knocked client #15 down; client #15 sustained a concussion and was hospitalized
- 5/9/19, client #11 hit another client (client #38) but no injury was noted
- 9/11/19, after being transported to the facility, client #11 hit a peer (client #34) on her knees
- 9/11/19, after entering the facility, client #11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL046-033	A. BUILDING: _____ B. WING _____	10/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHOANOKE VALLEY	1321 WEST FIRST STREET AHOSKIE, NC 27910

(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 3	V 108		

entered another class room and hit another client (#38) on the side of the head with a closed fist; when staff #2 intervened, client #11 hit staff #2
- 9/23/19, while clients got on the van, client #11 hit a peer (client #39) on the left side of the face with a closed fist

Review on 10/1/19 of client #11's behavior log revealed:
- 3 documented behaviors: 5/15/18; 5/9/19 & 9/27/19

Review on 10/1/19 of a hospital discharge summary for client #15 revealed:
- "admitted 5/9/19 & discharged 5/11/19"
- "...assaulted by another resident" (client #11)
- "diagnoses: abrasion of face (right cheek) & small subarachnoid hemorrhage" (bleeding in the space between the brain and the tissue covering the brain)

Review on 10/1/19 of hospital documentation for client #17 revealed:
- on 6/3/19, client #17 was transported to the emergency department of a local hospital after client #11 struck her on the back of the head resulting in a hematoma
- there was no loss of consciousness or evidence of intercranial hemorrhage

During interview on 10/1/19 client #2 reported:
- one time client #11 hit him on his shoulder
- it started to pain after awhile
- he did not receive medical attention
- staff was there & told him (#2) to rest his shoulder

During interview on 10/1/19 client #6 reported:
- she does not like client #11
- he hit her and made her cry

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL046-033	A. BUILDING: _____ B. WING _____	10/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHOANOKE VALLEY	1321 WEST FIRST STREET AHOSKIE, NC 27910

(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 4 - she doesn't know why he hit her - staff saw it and moved client #11 During interview on 10/1/19 client #10 reported: - client #11 has not hit her but has hit others - client #11 picked on client #15 - he pushed client #15 down and his head started bleeding - client #11 pushed him down for no reason - client #15 was not doing anything During interview on 10/1/19 client #11 reported: - been 4-5 years ago since he hit a client - he did hit a client (#15) in May - he (client #15) got in his space - he pushed him (#15) in the chest - client #15 had to go to the hospital Observation at 2:02 pm on 10/1/19 an attempted interview with client #15 revealed: - he was nonverbal - whined (faint cry) as suveyor attempted to engage - a gaitbelt around the waist During interview on 10/1/19 client #16 reported: - client #11 hit her one time in the back of the head - it hurt - she was shocked - no medical attention was needed - staff removed him During interview on 10/1/19 client #17 reported: - client #11 hit her on the back of the head and caused a "knot" - she was taken to the hospital - staff told her "not to get around him" During interview on 10/1/19 client #34 reported:	V 108		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL046-033	A. BUILDING: _____ B. WING _____	10/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHOANOKE VALLEY	1321 WEST FIRST STREET AHOSKIE, NC 27910

(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 5 - client #11 was "not nice" - hit her on her leg while she was on the van for no reason. During an interview on 10/1/19 client #32 reported: - client #11 hit him once but he pushed client #11 back - he was not sure why client #11 hit him. During interview on 10/8/19 client #38 reported: - client #11 came into his classroom and hit him with his fist - it caused his glasses to fall off - he wanted to call the police but staff told him not to. During interview on 10/8/19 client #42 reported: - he felt safe now that client #11 was "isolated" - on the day client #11 knocked client #15 down, client #11 also hit him with an object - he tried to get out of client #11's way but he hit him anyway - client #11 was "dangerous." During an interview on 10/1/19, staff #2 reported: - she had worked at the facility almost 2 years - she worked with client #11 one on one (1:1) almost a year - she had completed some incident reports on client #11 due to him getting "hyped out" and being aggressive - client #11 was Autistic - she had no training in working with clients with Autism - she was with client #11 when he went after client #15; she attempted to block client #11 with her body but he reached around her and pushed client #15 and caused him to fall and hit his head	V 108		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL046-033	A. BUILDING: _____ B. WING _____	10/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHOANOKE VALLEY	1321 WEST FIRST STREET AHOSKIE, NC 27910

(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 6 During interview on 10/1/19 FS#5 reported: - she last worked at the facility on 7/12/19 - she worked for 3 months at the facility - she left due to the pay - she was the 1:1 for client #15 - she worked a few times with client #11 - she recalled in May 2019 client #11 hit client #15 for no reason - it happened so fast - client #15 went to the hospital - she was not trained in Autism - Autism training would have been beneficial to help her do a better job with client #11 During an interview on 10/8/19, staff #3 reported: - she had worked at the facility since November 2018 - she worked 1:1 with client #11, off and on, between November 2018 and July 2019 - she worked with client #15 1:1 now ; she tried to keep client #15 away from client #11 because client #11 had assaulted client #15 twice - she was not sure if she had received training in working with clients with Autism During an interview on 10/8/19, staff #1 reported: - she had worked at the facility since December 2018 - she had reviewed some client's books but had not had actual training on diagnoses other than Schizophrenia, Bipolar Disorder and Traumatic Brian Injury - she currently worked 1:1 with client #11 - she had no training on working with clients with Autism but believed client #11 was Autistic - the Medical Record staff told her signs and triggers to look for while working with client #11 - she thought client #11 targeted clients that were weaker than him - she believed training in Autism would be	V 108		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL046-033	A. BUILDING: _____ B. WING _____	10/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHOANOKE VALLEY	1321 WEST FIRST STREET AHOSKIE, NC 27910

(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 7 beneficial During an interviews on 10/1/19 and 10/8/19, the Day Activity Director reported: - she had worked at the facility 8 years and had been a QP for 8 years - client #11 was not assigned to her area - client #11 once entered her classroom and assaulted a client for no reason - she blocked him with her body to prevent him from attacking other clients until his 1:1 staff was able to get him to leave the room - she had no training on working with clients with Autism During interview on 10/1/19 the Care Coordinator for client #11 reported: - she had been the Care Coordinator since June 2019 - she had not met client #11 but planned to meet him this week - client #11's mom contacted her about training in Autism for staff - she had not sought any resources in Autism at this time Review on 10/8/19 of a Plan of Protection completed and signed by the Vice President of Clinical Operations on 10/8/19 revealed: What immediate action will the facility take to ensure the safety of the consumers in your care? Solid Foundation will continue to provide client specific trainings to staff, which will be specific to the clients' needs. The agency will utilize a variety of training techniques to staff to ensure staff are competent and understand trainings. Describe your plans to make sure the above happens.	V 108		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL046-033	A. BUILDING: _____ B. WING _____	10/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHOANOKE VALLEY	1321 WEST FIRST STREET AHOSKIE, NC 27910

(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 8 The agency's QPs (Qualified Professionals) will be responsible for implementing trainings (i.e. Autism Training). QPs will be responsible for ensuring all trained staff successfully complete trainings. Staff are responsible for demonstrating competence in areas of training. QPs will provide in-house training. Provider will continue to research trainings available outside of the agency. Client #11 was admitted in March 2014 with diagnoses of Autism and IDD. An audited sample of personnel records on 9/26/19 revealed staff hire dates ranged from 2013-2019 with no training in Autism. The facility's IRIS report, General Event reports and Quality Assurance Committee reports had a total of 7 incidents of aggression by client #11 between January 2019 and September 2019. Client #11 had hit clients with closed fist in the side of the head and had hit a staff. Two clients were taken to the hospital, one with a hematoma and the other one was hospitalized with small subarachnoid hemorrhage. Client #11 has since been assigned a 1:1 worker; assigned his own classroom and services have been increased in the community. Several staff reported they were not trained in Autism, however, a fax was received at DHSR that staff were trained in Autism in June 2019. This deficiency constitutes a Type B rule violation which is detrimental to the health, safety or welfare of the clients. If the violation is not corrected within 45 days, an administrative penalty of $200.00 per day will be imposed for each day the facility is out of compliance beyond the 45th day.	V 108		
V 119	27G .0209 (D) Medication Requirements	V 119		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL046-033	A. BUILDING: _____ B. WING _____	10/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHOANOKE VALLEY	1321 WEST FIRST STREET AHOSKIE, NC 27910

(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 119	Continued From page 9 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (d) Medication disposal: (1) All prescription and non-prescription medication shall be disposed of in a manner that guards against diversion or accidental ingestion. (2) Non-controlled substances shall be disposed of by incineration, flushing into septic or sewer system, or by transfer to a local pharmacy for destruction. A record of the medication disposal shall be maintained by the program. Documentation shall specify the client's name, medication name, strength, quantity, disposal date and method, the signature of the person disposing of medication, and the person witnessing destruction. (3) Controlled substances shall be disposed of in accordance with the North Carolina Controlled Substances Act, G.S. 90, Article 5, including any subsequent amendments. (4) Upon discharge of a patient or resident, the remainder of his or her drug supply shall be disposed of promptly unless it is reasonably expected that the patient or resident shall return to the facility and in such case, the remaining drug supply shall not be held for more than 30 calendar days after the date of discharge. This Rule is not met as evidenced by: Based on observation, record review and interview the facility failed to dispose of medications in a manner that guarded against diversion or accidental ingestion. The findings are: Observation on 9/26/19 at 11:03am revealed	V 119		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL046-033	A. BUILDING: _____ B. WING _____	10/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHOANOKE VALLEY	1321 WEST FIRST STREET AHOSKIE, NC 27910

(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 119	Continued From page 10 expired medications in the medication drawer: - client #10: ProAir (use as needed) dispensed 8/8/16 & expired 2/4/17 (used to prevent bronchospasm) - client #20: Sucralfate 1gram: take four times a day before meals (dispensed 3/1/19 & expired 7/27/19) (used to treat stomach ulcers) - 11:26am the Program Director placed the expired medication in a brown envelope During interview on 9/26/19 the Program Director reported: - client #10 & #20 no longer used the medications - the expired medications needed to be returned to the facility - she was responsible for ensuring expired medications were returned to the facility - she got behind on returning the medications back to the facility - the expired medications would be returned to the facility today (9/26/19)	V 119		
V 120	27G .0209 (E) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (e) Medication Storage: (1) All medication shall be stored: (A) in a securely locked cabinet in a clean, well-lighted, ventilated room between 59 degrees and 86 degrees Fahrenheit; (B) in a refrigerator, if required, between 36 degrees and 46 degrees Fahrenheit. If the refrigerator is used for food items, medications shall be kept in a separate, locked compartment or container; (C) separately for each client; (D) separately for external and internal use;	V 120		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL046-033	A. BUILDING: _____ B. WING _____	10/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHOANOKE VALLEY	1321 WEST FIRST STREET AHOSKIE, NC 27910

(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 120	Continued From page 11 (E) in a secure manner if approved by a physician for a client to self-medicate. (2) Each facility that maintains stocks of controlled substances shall be currently registered under the North Carolina Controlled Substances Act, G.S. 90, Article 5, including any subsequent amendments. This Rule is not met as evidenced by: Based on observation and interview, the governing body failed to assure medications were stored separately for each client. The findings are: Observation on 9/26/19 at approximately 11:00 AM of the medication room revealed a box that contained medications for several clients. Review of the medications revealed the following were present: - client #19's Lorazepam 0.5 milligrams (mg) tablets - client #15's Lorazepam 0.5 mg tablets - client #18's Lorazepam 1 mg tablets and chlorpromazine 100 mg tablets - client #16's Tegretol XR 400 mg tablets - client #20's Gabapentin 300 mg tablet During an interview on 9/26/19 the Adult Developmental Vocational Program Director reported the above medications were administered on site, however she was not aware medications needed to be stored separately per client.	V 120		
V 367	27G .0604 Incident Reporting Requirements 10A NCAC 27G .0604 INCIDENT	V 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL046-033	A. BUILDING: _____ B. WING _____	10/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHOANOKE VALLEY	1321 WEST FIRST STREET AHOSKIE, NC 27910

(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 367	Continued From page 12 REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall report all level II incidents, except deaths, that occur during the provision of billable services or while the consumer is on the providers premises or level III incidents and level II deaths involving the clients to whom the provider rendered any service within 90 days prior to the incident to the LME responsible for the catchment area where services are provided within 72 hours of becoming aware of the incident. The report shall be submitted on a form provided by the Secretary. The report may be submitted via mail, in person, facsimile or encrypted electronic means. The report shall include the following information: (1) reporting provider contact and identification information; (2) client identification information; (3) type of incident; (4) description of incident; (5) status of the effort to determine the cause of the incident; and (6) other individuals or authorities notified or responding. (b) Category A and B providers shall explain any missing or incomplete information. The provider shall submit an updated report to all required report recipients by the end of the next business day whenever: (1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or (2) the provider obtains information required on the incident form that was previously unavailable. (c) Category A and B providers shall submit, upon request by the LME, other information	V 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL046-033	A. BUILDING: _____ B. WING _____	10/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHOANOKE VALLEY	1321 WEST FIRST STREET AHOSKIE, NC 27910

(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 367	Continued From page 13 obtained regarding the incident, including: (1) hospital records including confidential information; (2) reports by other authorities; and (3) the provider's response to the incident. (d) Category A and B providers shall send a copy of all level III incident reports to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of becoming aware of the incident. Category A providers shall send a copy of all level III incidents involving a client death to the Division of Health Service Regulation within 72 hours of becoming aware of the incident. In cases of client death within seven days of use of seclusion or restraint, the provider shall report the death immediately, as required by 10A NCAC 26C .0300 and 10A NCAC 27E .0104(e)(18). (e) Category A and B providers shall send a report quarterly to the LME responsible for the catchment area where services are provided. The report shall be submitted on a form provided by the Secretary via electronic means and shall include summary information as follows: (1) medication errors that do not meet the definition of a level II or level III incident; (2) restrictive interventions that do not meet the definition of a level II or level III incident; (3) searches of a client or his living area; (4) seizures of client property or property in the possession of a client; (5) the total number of level II and level III incidents that occurred; and (6) a statement indicating that there have been no reportable incidents whenever no incidents have occurred during the quarter that meet any of the criteria as set forth in Paragraphs (a) and (d) of this Rule and Subparagraphs (1) through (4) of this Paragraph.	V 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL046-033	A. BUILDING: _____ B. WING _____	10/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHOANOKE VALLEY	1321 WEST FIRST STREET AHOSKIE, NC 27910

(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 367	Continued From page 14 This Rule is not met as evidenced by: Based on record review and interview, the governing body failed to assure a level II incident for 1 of 7 audited clients (#41) was reported to the local management entity within 72 hours. The findings are: During an interview on 10/1/19, the Day Activity Director (DA Director) reported the police were called in August when client #41 "went off" on a peer. The police arrived and spoke with client #41 and his sister later arrived to take him home. The DA Director reported no incident report was completed. During an interview on 10/1/19, the Administrator reported on the day in question, client #41 and a family member were at odds and when client #41 arrived at the facility, he was "out of sorts". The Administrator reported she told the Adult Developmental Vocational Program Director to seek involuntary commitment for client#41. The Administrator reported the client's sister decided to pick him up rather than have him committed. During an interview on 10/8/19, the Vice President of Clinical Operations reported she thought since the police were on site just to transport a client for possible involuntary commitment, no level II incident report was required.	V 367		