Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(3) DATE SURVEY COMPLETED	
		MHL033-115	B. WING		10/2	5/2019
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
SHERRO	D ALTERNATIVE		AMORE STF OUNT, NC			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
V 000	INITIAL COMMENT	-S	V 000			
	10/25/19. Deficienc The facility is licens	ed for the following service 27G .5600F Supervised				
V 110	27G .0204 Training. Paraprofessionals 10A NCAC 27G .02 SUPERVISION OF (a) There shall be reparaprofessionals. (b) Paraprofessionals associate professional as special subchapter. (c) Paraprofessional subchapter. (c) Paraprofessional subchapter. (d) At such time as employment system then qualified professionals shall of the such time as the subchapter.	/Supervision 04 COMPETENCIES AND PARAPROFESSIONALS no privileging requirements for alls shall be supervised by an nal or by a qualified cified in Rule .0104 of this alls shall demonstrate nd abilities required by the a competency-based is established by rulemaking, ssionals and associate demonstrate competence. nall be demonstrated by including:	V 110			
	(2) cultural awaren (3) analytical skills; (4) decision-makin (5) interpersonal skills (6) communication (7) clinical skills. (f) The governing become and implementation of the skills.	ess; g; kills;				

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

(X6) DATE TITLE

Division of Health Service Regulation

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL033-115	B. WING		10/2	5/2019
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
SHERRO	DD ALTERNATIVE		AMORE STE			
(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 110	Continued From pa	ge 1	V 110			
	This Pulo is not me	ot as ovidenced by:				
	failed to ensure 2 o demonstrated the k	view and interview the facility f 3 staff (Licensee & staff #1) knowledge, skills and abilities bulation served. The findings				
		9 of client #1's record				
	by history; Delusior Schizophrenia - a treatment pla	ost Traumatic Stress Disorder nal Disorder; Autism & n dated 1/11/19"attends eek for computer classes"				
	of Health Service R revealed: "[client #1 of September wher wanted to take over	9 of a fax sent to the Division Regulation from the Licensee I] gave \$260.00 in the month he got his school refund. He r his phone bill and keep his \$149.00 plus taxwe				
	previously discusse has been a misund given \$140.00 back	ed gas to [college]since there erstanding[client #1] was for the cost of the phone and signed by Licensee & client #1				
	- he received his his school	10/15/19 client #1 reported: student loan last month from				
	- he was not sure but he gave it to he	sked for \$300.00 of it e why she wanted the \$300.00 r censee's son (staff #1) got into				

Division of Health Service Regulation

STATE FORM SSN611 If continuation sheet 2 of 10

Division of Health Service Regulation

Division of Health Service Regulation							
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LEIED	
		MHL033-115	B. WING		10/2	5/2019	
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY. S	STATE, ZIP CODE			
			AMORE STR				
SHERRO	D ALTERNATIVE		OUNT, NC				
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON	(X5)	
PREFIX		MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL		COMPLETE DATE	
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO DEFICIENCY)	PRIATE	DATE	
				•			
V 110	Continued From pa	ge 2	V 110				
	a physical altercation	on last month					
	- he did not like t	he why staff #1 disrespected					
	his mother (License						
		as not his business but he					
	•	#1 on the side of the neck					
		in the back of the head					
	- there were no in	nurt staff #1 but he stopped					
	the fight	idit stall #1 but lie stopped					
		atched and did not try to stop					
	it						
	- he does not red	all anyone else being at the					
	facility						
	During interview on	10/15/10 alignt #1's guardian					
	reported:	10/15/19 client #1's guardian					
		her aware of the \$300.00 & an					
	incident with staff #						
		uled a meeting with the					
	Qualified Profession	nal and Licensee					
	.	40/47/40 !! OD !!! !!					
		10/17/19 the QP with the					
	case management	dian made him aware of the					
	_	ident with staff #1 today					
	•	Il be investigated					
		3					
		10/24/19 staff #1 reported:					
	- he has been sta						
		ncidents between him and					
	client #1	retched the incident that					
		ind his mom (Licensee)					
	- him and the Lic						
		1 was in his bedroomhe					
		ctly what client #1 said but it					
		dn't be talking to your mom					
		ient #1 that was between him					
	and his mother						

Division of Health Service Regulation

he does not recall what him and his mother

STATE FORM SSN611 If continuation sheet 3 of 10

Division	<u>of Health Service Re</u>	egulation				
AND DIAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		MHL033-115	B. WING		10/2	5/2019
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
SHERRO	D ALTERNATIVE		AMORE STR			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
V 110	- he went to his bleave for church - when he (staff at the yard doing mars) - as he walked by and he blocked the - he was afraid come he (staff #1) gode he didn't think at him and client at issues since that in the buring interview on the buring interview on the buring verbal exchanged as he always talk somethingdo not she always talk somethingdo not she always talk something like he come the client #1 was in something like he do her (Licensee) - staff #1 said "the mother" - he left for church he left for church he received he she purchased paid client #1's cell (\$120.00)she also to school (August, Section of the writing)	oly about cleaning up" bedroom and got his guitar to #1) got outside client #1 was in shal arts y client #1 kicked towards him kick lient #1 would hit his guitar t in his vehicle and left anything of the incident #1 have engaged with no cident 10/15/19 & 10/24/19 the ent #1 and her son (staff #1) ange but nothing physical ed to staff #1 about recall the discussion between hat day the facility that day and said lidn't like how staff #1 spoke to his is between me and my	V 110			
V 118		ication Requirements	V 118			

6899

Division of Health Service Regulation STATE FORM

If continuation sheet 4 of 10 SSN611

Division of Health Service Regulation

DIVISION	of Health Service Re	eguiation				
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
		MHL033-115	B. WING		10/2	5/2019
NAME OF I	PROVIDER OR SUPPLIER	STDEET AD	DDESS CITY S	STATE, ZIP CODE		
INAME OF I	NOVIDEN ON SOIT EIEN		AMORE STF			
SHERRO	D ALTERNATIVE		IOUNT, NC			
	OLIMANA DV. OTA				<u></u>	0.171
(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 4	V 118			
	10A NCAC 27G .02	209 MEDICATION				
	REQUIREMENTS					
	(c) Medication adm					
		non-prescription drugs shall				
		ed to a client on the written				
		uthorized by law to prescribe				
	drugs.	all be self-administered by				
		uthorized in writing by the				
	client's physician.	ationzed in writing by the				
		cluding injections, shall be				
		y licensed persons, or by				
		trained by a registered nurse,				
		legally qualified person and				
		e and administer medications.				
		Iministration Record (MAR) of				
	•	red to each client must be kept s administered shall be				
		ely after administration. The				
	MAR is to include the					
	(A) client's name;	ar a constraint g				
		and quantity of the drug;				
	(C) instructions for	administering the drug;				
		ne drug is administered; and				
		of person administering the				
	drug.	for modication description				
		for medication changes or				
		orded and kept with the MAR appointment or consultation				
	with a physician.	appointment of consultation				
	a prijoiolarii					
	This Rule is not me					
		view and interview the facility				
		s current and record				
	immediately after a	dministration for 2 of 3 clients				

Division of Health Service Regulation

(#1 & #2). The facility failed to follow a physician's

STATE FORM SSN611 If continuation sheet 5 of 10

Division	<u>of Health Service Re</u>	guiation				
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		MHL033-115	B. WING		10/2	5/2019
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
SHERRO	D ALTERNATIVE		AMORE STR			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
V 118	Review on 10/15/19 revealed: - admitted 2/21/11 - diagnoses of Poby history; Delusion Schizophrenia - a physician's or Aripiprazole 2mg exschizophrenia)tap Review on 10/15/19 MAR revealed: - staff initialed Mark revealed: - she copied the she mistakenly October 2019 MAR - the Aripiprazole B. Review on 10/15 revealed: - admitted 6/1/18 - diagnoses of M Disorder (IDD) and - a physician's or 5mg 3 bedtime (car disorders) - a physician's or 3mg at bedtime (car Review on 10/15/19/2019 MAR revealed: - Clonidine was r August 2019	of client #1's record gost Traumatic Stress Disorder al Disorder; Autism & der dated 7/12/19: veryday (can treat per & discontinue gof client #1's October 2019 AR from October 1 - 15 10/15/19 the Licensee MAR from the previous month wrote Aripiprazole on the was discontinued /19 of client #2's record gild Intellectual Developmental Schizophrenia der dated 8/9/19: Haloperidol on treat certain types of mental entereat high blood pressure) gof an August 2019 & October discontinued the discontinued of the dated for the discontinued of the dated 5/21/19: Clonidine on treat high blood pressure) gof an August 2019 & October discontinued the entire month of the discontinued of the discontinued of the entire month of the discontinued o	V 118			
		s not initialed from October 1 -				

14, 2019 Division of Health Service Regulation

STATE FORM 6899 If continuation sheet 6 of 10 SSN611

Division of Health Service Regulation

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL033-115	B. WING		10/2	5/2019
NAME OF F	PROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, S	STATE, ZIP CODE	-	
SHERRO	D ALTERNATIVE		AMORE STR			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFILIENCY)	D BE	(X5) COMPLETE DATE
V 118	Continued From pa	ge 6	V 118			
	During interview on reported: - she forgot to ini Haloperidol & Cloni - client #2 received. C. Review on 10/15 revealed: - admitted 1/6/17 - diagnoses of Proceeding to the diagnoses of Proceeding twice a day (of the matter of	10/15/19 the Licensee itial the medications dine on the MAR ed his medications 5/19 of client #3's record rofound IDD; Cerebral Palsy & er dated 9/11/19: Lamotrigine can seizures) 9 of client #3's of October 2019 mg twice a day was typed in 15/19 at 2:38pm of client #3's vealed:				
		10/17/19 the QP reported: the medication errors				
V 290	27G .5602 Supervis	sed Living - Staff	V 290			
	numbers specified i	SO2 STAFF os above the minimum in Paragraphs (b), (c) and (d) e determined by the facility to				

Division of Health Service Regulation

STATE FORM SSN611 If continuation sheet 7 of 10

Division of Health Service Regulation

DIVISION	of Health Service Re	guiation				
AND DIAN OF CORRECTION IN INCREME		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		MHL033-115	B. WING		10/2	25/2019
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
OUEDDO	D ALTEDNIATIVE	1233 SYC	AMORE STR	REET		
SHEKKU	DD ALTERNATIVE	ROCKY M	OUNT, NC 2	27801		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST 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 290	Continued From pa	ge 7	V 290			
	enable staff to resp needs. (b) A minimum of opersent at all times premises, except whabilitation plan doc capable of remaining without supervision as needed but not I the client continues the home or commispecified periods of (c) Staff shall be presented in the client continues the home or commispecified periods of (c) Staff shall be presented in the client continues the home or commispecified periods of (c) Staff shall be presented in the pr	ond to individualized client one staff member shall be when any adult client is on the hen the client's treatment or cuments that the client is ing in the home or community. The plan shall be reviewed ess than annually to ensure to be capable of remaining in unity without supervision for itime. The seent in a facility in the fratios when more than one client is present: The adolescents with substance all be served with a minimum for every five or fewer minor to every four or the procedures determined by the or procedures with the pr				

Division of Health Service Regulation

Division of Health Service Regulation

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL033-115	B. WING		10/2	5/2019
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
SHERRO	D ALTERNATIVE		AMORE STR			
			OUNT, NC			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
V 290	Continued From pa	ge 8	V 290			
	as-needed basis fo	r each client.				
	failed to ensure a m present at all times treatment plan docu	view and interview the facility ninium of one staff was was except when the client's umented the client was ag in the community for 2 of 3				
	revealed: - admitted 2/21/1 - diagnoses of Poby history; Delusion Schizophrenia - a treatment pla unsupervised time store and restaurar - unsupervised diagrams.	ost Traumatic Stress Disorder all Disorder; Autism & n dated 1/11/19 with no documented for walks to local				
	 he was allowed local resturants During interview on reported: she was aware time in the commur he walked to th the Qualified Proposed to put in the community 	to walk to the store & the 10/15/19 client #1's guardian client #1 had unsupervised nity e local store rofessional (QP) was the treatment plan				
	revealed: - admitted 6/1/18	i/19 of client #2's record				

Division of Health Service Regulation

diagnoses of Mild Intellectual Disability and

STATE FORM SSN611 If continuation sheet 9 of 10

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED	
		MHL033-115	B. WING		10/2	25/2019
	PROVIDER OR SUPPLIER DD ALTERNATIVE	1233 SYC	CAMORE STE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETE DATE
V 290	Schizophrenia - a treatment pla unsupervised time of During interview on - he was allowed During interview on Licensee reported: - client #1 & #2 h - she has reques unsupervised time is several occasions During interview on - client #1 & client	n dated 2/6/19 with no	V 290			

Division of Health Service Regulation STATE FORM

SSN611 If continuation sheet 10 of 10