|           | TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  |  | (X2) MULTIPL<br>A. BUILDING: | E CONSTRUCTION |   | (X3) DATE SURVEY<br>COMPLETED                  |          |  |
|-----------|--|--|------------------------------|----------------|---|--|----------|--|
|           |  | MHL007-027   |                              | B. WING        |   | 01/2   | 24/2020  |  |
| NAME OF I | PROVIDER OR SUPPLIER   | S1   | REET ADI                     | DRESS, CITY, S | STATE, ZIP CODE   |  |          |  |
|           | 903 EAST SEVENTH STREET  |  |                              |                |   |  |          |  |
| BEAUFO    | RT COUNTY GROUP  | HOMF #2  |                              | TON, NC 27     |   |  |          |  |
| (X4) ID   | SUMMARY STA  | TEMENT OF DEFICIENCIES                             |                              | ID             | PROVIDER'S PLAN OF (                                    | CORRECTION                                     | (X5)     |  |
| PRÉFIX    | (EACH DEFICIENCY   | MUST BE PRECEDED BY FUL                            |                              | PREFIX         | (EACH CORRECTIVE ACTI                                   | ON SHOULD BE                                   | COMPLETE |  |
| TAG       | REGULATORY OR L  | SC IDENTIFYING INFORMATIO                          | N)                           | TAG            | CROSS-REFERENCED TO |  | DATE     |  |
|           |  |  |                              |                |   | <u>,                                      </u> |          |  |
| V 000     | INITIAL COMMENT  | TS .   |                              | V 000          |   |  |          |  |
|           |  |  |                              |                |   |  |          |  |
|           |  | as completed on Janua                              | ıry 24,                      |                |   |  |          |  |
|           | 2020. A deficiency v   | was cited.   |                              |                |   |  |          |  |
|           | This facility is licens  | sed for the following ser                          | vice                         |                |   |  |          |  |
|           |  | C 27G. 5600C Supervis                              |                              |                |   |  |          |  |
|           |  | h Developmental Disab                              |                              |                |   |  |          |  |
|           | -  |  |                              |                |   |  |          |  |
| V 291     | 27G .5603 Supervis   | sed Living - Operations                            |                              | V 291          |   |  |          |  |
|           |  |  |                              |                |   |  |          |  |
|           | 10A NCAC 27G .56   |  |                              |                |   |  |          |  |
|           |  | cility shall serve no more                         |                              |                |   |  |          |  |
|           | six clients when the clients have mental illness or<br>developmental disabilities. Any facility licensed<br>on June 15, 2001, and providing services to more |  |                              |                |   |  |          |  |
|           |  |  |                              |                |   |  |          |  |
|           | than six clients at that time, may continue to provide services at no more than the facility's   |  |                              |                |   |  |          |  |
|           |  |  |                              |                |   |  |          |  |
|           | licensed capacity.   |  |                              |                |   |  |          |  |
|           |  | nation. Coordination sh                            |                              |                |   |  |          |  |
|           |  | n the facility operator an                         |                              |                |   |  |          |  |
|           |  | als who are responsible                            |                              |                |   |  |          |  |
|           |  | on or case management                              | [.                           |                |   |  |          |  |
|           |  | the Family or Legally  n. Each client shall be     |                              |                |   |  |          |  |
|           |  | unity to maintain an ong                           | going                        |                |   |  |          |  |
|           |  | r or his family through s                          |                              |                |   |  |          |  |
|           |  | he facility and visits out                         |                              |                |   |  |          |  |
|           |  | s shall be submitted at le                         |                              |                |   |  |          |  |
|           |  | ent of a minor resident,                           |                              |                |   |  |          |  |
|           |  | person of an adult resid                           |                              |                |   |  |          |  |
|           |  | writing or take the form all focus on the client's | от а                         |                |   |  |          |  |
|           |  | eeting individual goals.                           |                              |                |   |  |          |  |
|           |  | ies. Each client shall h                           | ave                          |                |   |  |          |  |
|           |  | s based on her/his choi                            |                              |                |   |  |          |  |
|           |  | ment/habilitation plan.                            | •                            |                |   |  |          |  |
|           |  | esigned to foster comm                             |                              |                |   |  |          |  |
|           |  | may be limited when th                             |                              |                |   |  |          |  |
|           |  | or when health                                     | or                           |                |   |  |          |  |
|           | satety issues becon  | ne a primary concern.                              |                              |                |   |  |          |  |

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

(X6) DATE TITLE

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |  | (X2) MULTIPLE CONSTRUCTION  A. BUILDING:  |   |  | X3) DATE SURVEY<br>COMPLETED    |                          |
|--|--|---|---|--|---------------------------------|--------------------------|
|  |  | MHL007-027  | B. WING                                       |  | 01/                             | 24/2020                  |
|  | PROVIDER OR SUPPLIER  PRT COUNTY GROUP   | HOMF #2 903 EAS   | DDRESS, CITY, S<br>T SEVENTH S<br>GTON, NC 27 | TREET  |                                 |                          |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG                           | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO T<br>DEFICIENC | ION SHOULD BE<br>HE APPROPRIATE | (X5)<br>COMPLETE<br>DATE |
| V 291  | This Rule is not me Based on record re facility failed to mai facility operator and responsible for the one of three audited Review on 1/23/20 - 49-year-old male Admission date of - Diagnoses of Auti-Accompanying Intel Impairment, and Se Developmental Distriction (FSBS) values bein | et as evidenced by: views and interviews, the ntain coordination between the It the professionals who are client's treatment, affecting d clients (#1). The findings are of client #3's record revealed: 603/01/07. sm Spectrum Disorder with llectual and Language   |   |  |                                 |                          |
|  | medication review of following medication - Novolog Flex Pen Inject subcutaneous lunch Novolog Flex Pen 1 extra unit for ever over 130 Basaglar (treats d subcutaneously twingurans - Give 1 tuber than 60 or if having - Blood Sugar Checand at bedtime.                                  | of client #1's signed dated 12/27/19 revealed the n and orders: (treats diabetes) 5 units - sly daily before breakfast and (treats diabetes) 1 unit - Injecty 50 points that blood sugar is iabetes) 16 units - Injectice a day as needed. Its hypoglycemic reaction) 15 by mouth if glucose is less symptoms of hypoglycemia. Its check levels before meals of client #1's Person-Center |   |  |                                 |                          |

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Division of Health Service Regulation STATE FORM

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   |                     |   |       | DATE SURVEY<br>COMPLETED |  |
|---|---|--|---------------------|---|-------|--------------------------|--|
| 7.1.2.7.2.11.01.00.11.120.11.01.                    |   |  | A. BUILDING:        | ·   |       |                          |  |
|   |   | MHL007-027   | B. WING             |   | 01/2  | 4/2020                   |  |
| NAME OF I   | PROVIDER OR SUPPLIER  | STREET AD  | DRESS, CITY, S      | STATE, ZIP CODE   |       |                          |  |
| BEAUFO  | RT COUNTY GROUP   | HOMF #2  | SEVENTH S           |   |       |                          |  |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIENCY  | NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY) | .D BE | (X5)<br>COMPLETE<br>DATE |  |
| V 291   | times per day prefer night. He receives I (milliliter) - Inject 15 morning and at bed 100U/ML (units/millilinger 5 units Subcard lunch, inject 6 evening before suppoints that blood suare less than 130 b 200 post meals. PF Glucose 45 Gel-giv than 60mg/DL (millilingsymptoms of hypogen Review on 1/24/20 Blood Glucose Log values: - 12/01/19: 266-11:: - 12/02/19: 240-6:0 - 12/03/19: 238-11:: - 12/04/19: 289-11:: - 12/06/19: 275-9:0 - 12/08/19: 229-8:0 - 12/11/19: 254-5:00 - 12/13/19: 212-7:0 - 12/14/19: 216-7:3 | /19 revealed: is blood sugar checked 4 erably before meals and at Lantus Solostar 100 units/ML founits subcutaneously every eltime. Humalog Kwikpen- liliters) Inject- Subcutaneously eutaneously before breakfast units, subcutaneously every per. Take 1 extra unit for 50 lugar is over 130. Goal sugars lefore meals, and less than RN- Give one tube by mouth if lee one tube by mouth if less ligrams/deciliter) or if having glycemia."  of client #1's December-2019 revealed the following FSBS  30am, and 251-8:30pm. 0pm. 0pm. 0pm. 0pm. 0pm. 0pm. 0am. 0am, 0am, 0am, 0am, 0am, 0am, 0am, 0am, | V 291               |   |       |                          |  |

Division of Health Service Regulation

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:        | (X2) MULTIPLE CONSTRUCTION |   | (X3) DATE SURVEY<br>COMPLETED |                  |
|--|---|---|----------------------------|---|-------------------------------|------------------|
| 71142 1 27114                                    | AND TERM OF CONTROL INC.  |   | A. BUILDING:               |   | OOM                           | LLILD            |
|  |   | MHL007-027  | B. WING                    |   | 01/2                          | 4/2020           |
| NAME OF  | PROVIDER OR SUPPLIER  | STREET AL   | DDRESS, CITY, S            | STATE, ZIP CODE   |                               |                  |
| BEAUFO   | RT COUNTY GROUP   | HOMF #2   | T SEVENTH S<br>GTON, NC 27 |   |                               |                  |
| (X4) ID  | SUMMARY STA   | ATEMENT OF DEFICIENCIES                                   | ID                         | PROVIDER'S PLAN OF CORREC   | ΓΙΟΝ                          | (X5)             |
| PREFIX<br>TAG                                    |   | Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION) | PREFIX<br>TAG              | (EACH CORRECTIVE ACTION SHOI<br>CROSS-REFERENCED TO THE APPR<br>DEFICIENCY) |                               | COMPLETE<br>DATE |
| V 291  | Continued From pa   | nge 3   | V 291                      |   |                               |                  |
| V 291  | - 11/06/19: 248-8:3 - 11/07/19: 217-8:30 - 11/10/19: 211-8:00 - 11/15/19: 284-8:00 - 11/16/19: 290-7:30 - 11/17/19: 285-5:00 - 11/18/19: 207-6:30 - 11/21/19: 206-8:00 - 11/23/19: 238-8:00 - 11/28/19: 204-7:30 314-5:00pm, and 2 - 11/30/19 201-12:00 Review on 1/24/20 Blood Glucose Log values: - 10/01/19: 293-6:30 259-8:30pm 10/02/19: 238-11:30 - 10/05/19: 228-12:30 - 10/06/19: 201-7:30 252-5:00pm 10/08/19: 230-8:30 - 10/10/19: 230-8:30 - 10/10/19: 230-8:30 - 10/10/19: 230-8:30 - 10/10/19: 230-8:30 - 10/10/19: 201-6:30 - 10/11/19: 356-12: 388-8:30pm 10/13/19: 241-8:00 - 10/17/19: 382-5:00 - 10/18/19: 297-9:00 - 10/19/19: 235-12: 218-2:30pm. | Opm. Opm. Opm. Opm. Opm. Opm. Opm. Opm.                   | V 291                      |   |                               |                  |
|  | - 10/22/19: 249-6:3<br>- 10/24/19: 249-11:  | 0am.  |                            |   |                               |                  |

Division of Health Service Regulation

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |   | (X2) MULTIPLE CONSTRUCTION  A. BUILDING:   |   |   | (X3) DATE SURVEY<br>COMPLETED |                          |  |
|--|---|--|---|---|-------------------------------|--------------------------|--|
|  |   | MHL007-027   | B. WING   |   | 01/2                          | 24/2020                  |  |
|  | PROVIDER OR SUPPLIER  ORT COUNTY GROUP  | HOME #2 903 EAS  | DDRESS, CITY, STATE, ZIP CODE ST SEVENTH STREET IGTON, NC 27889 |   |                               |                          |  |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG   | PROVIDER'S PLAN OF COR<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE A<br>DEFICIENCY) | SHOULD BE                     | (X5)<br>COMPLETE<br>DATE |  |
| V 291  | regarding any FSBS range Any notifications of documented in shift Interview on 1/24/20 - When reviewing F values that were "noted that were | Opm. Opm. Opm. Opm. Opm. Opm. Opm. O staff #1 stated: ed client #1's physician S values outside the desired made to a physician would be t note. O staff #2 stated: SBS values he looked for ot too high or too low." quantify "too high or too low." O and 1/24/20 the Qualified: notified of any abnormal BP | V 291   |   |                               |                          |  |

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