STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	(X3) DATE SURVEY COMPLETED			
	MHL001-165		B. WING		R	20
					02/13/20	020
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
NEW DIN	MENSIONS INTERVEN	ITIONS INC	DERSON ROA STON, NC 27			
(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 APPRODEFICIENCY)	D BE CO	(X5) DMPLETE DATE
V 000	INITIAL COMMENT	rs .	V 000			
	on 2/13/20. Deficier The facility is licens	ed for the following service C 27 G .5600 A Supervised				
V 112	27G .0205 (C-D) Assessment/Treatn	nent/Habilitation Plan	V 112			
	TREATMENT/HABIPLAN (c) The plan shall to assessment, and in legally responsible of admission for clie receive services be (d) The plan shall i (1) client outcome(achieved by provisi projected date of ac (2) strategies; (3) staff responsibl (4) a schedule for annually in consultar responsible person (5) basis for evalua outcome achievem (6) written consent responsible party, consultar responsible party responsible party responsible party responsible party responsible party responsible party responsible	nclude: (s) that are anticipated to be on of the service and a chievement; e; review of the plan at least ation with the client or legally or both; ation or assessment of				

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

TITLE (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		
						R	
		MHL001-16	5	B. WING		02/	13/2020
	PROVIDER OR SUPPLIER		STATE, ZIP CODE				
NEW DI	MENSIONS INTERVEN	ITIONS, INC		TON, NC 27			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIEN MUST BE PRECEDEL SC IDENTIFYING INFO	D BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
V 112	12 Continued From page 1			V 112			
	This Rule is not me Based on record re facility failed to assist 3 clients (#1) was reare: Review on 2/13/20 - Admission date of Diagnoses of Bipodisorder; Chronic C (COPD) and Hyperl - A treatment plan in 7/20/18. No current treatment goals was found. Interview on 2/13/20 confirmed the above	views and intervieure the treatment eviewed annually of Client #1's recordant Disorder; Schobstructive Pulmolipidemia. In the client's recordant plan and with 0 with the Staff or	ews, the plan for 1 of . The findings ord revealed: nizoaffective onary Disease ord dated updated				
	This deficiency con- and must be correc						
V 118	27G .0209 (C) Med 10A NCAC 27G .02 REQUIREMENTS (c) Medication adm (1) Prescription or r only be administere order of a person adrugs. (2) Medications shadlients only when addients only when addient's physician. (3) Medications, incadministered only bunlicensed persons pharmacist or other	inistration: non-prescription of the to a client on the uthorized by law the all be self-administration uthorized in writing the trained by a regi	drugs shall ne written to prescribe stered by ng by the shall be ns, or by stered nurse,	V 118			

Division of Health Service Regulation

STATE FORM 6899 74ZE11 If continuation sheet 2 of 11

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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		MHL001-165	B. WING		02/1	3/2020
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
NEW DI	MENSIONS INTERVEN	ITIONS. INC	ERSON RO. TON, NC 27			
			ID ID	PROVIDER'S PLAN OF CORRECTION	ON.	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	COMPLETE DATE
V 118	Continued From pa	ge 2	V 118			
	privileged to prepar (4) A Medication Adall drugs administer current. Medication recorded immediate MAR is to include the (A) client's name; (B) name, strength, (C) instructions for (D) date and time the (E) name or initials drug. (5) Client requests checks shall be recorded.	e and administer medications. Iministration Record (MAR) of red to each client must be kept s administered shall be ely after administration. The				
	This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to assure written physician's orders were available for all medications being administered affecting 1 of 3 audited clients (#1) and medications ordered by a physician were available to be administered affecting 2 of 3 audited clients (#1 and #2.) The findings are: Review on 2/13/20 of Client #1's record revealed: - Admission date of 4/20/12 - Diagnoses of Bipolar Disorder; Schizoaffective Disorder; Chronic Obstructive Pulmonary Disease (COPD) and Hyperlipidemia January 2020 and February 2020 MAR's documenting the client was being administered included the following medication: 1) Vitamin D 5000, 1 every day					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
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		MHL001-165	B. WING		02/1	3/2020
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
NEW DIN	MENSIONS INTERVEN	ITIONS, INC	ERSON ROATON, NC 27			
(X4) ID PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
V 118	Continued From pa	ige 3	V 118			
	medication box revincluded the followi - 1) Vitamin D 5000 1/14/20 and Additional review or revealed: - No authorized phy	3/20 at 5:15PM of Client #1's ealed his medications-on-handing: b, with a dispense date of 1 2/13/20 of Client #1's record vsician's order was found for on to be administered to Client				
	Further review on 2/13/20 of Client #1's record revealed: - A physician's order for Ventolin HFA 90 micrograms (mcg) to be administered for wheezing related to the client's diagnosis of COPD as "Inhale 2 puffs every 4 hours as needed."					
	Client #1's medicat - No container of Ve	ion on 2/13/20 at 5:15PM of ion box revealed: entolin HFA 90 was available if he experienced wheezing.				
	Review on 2/13/20 of Client #2's record revealed: - Admission date of 8/24/20 - Diagnoses of Bipolar I Disorder and Diabetes - Physician's order dated 6/29/19 for the client to be administered Fluticasone Prop 50 micrograms (mcg,) one spray in each nostril two times a day.					
	Observation on 2/13/20 at 5:30PM of Client #2's medication box revealed: - No container of Fluticasone Prop 50 micrograms (mcg,) was included in the medications-on-hand in his medication box. Interview on 2/13/20 with the Staff on duty confirmed the above findings.					

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STATE FORM 6899 74ZE11 If continuation sheet 4 of 11

PRINTED: 02/26/2020 FORM APPROVED

DIVISION	of Health Service Re	eguiation					
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER		(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUM	BER:	A. BUILDING:		COMP	LETED
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		MHL001-165		B. WING			3/2020
		IIII LOOT 100				<u> </u>	3/2020
NAME OF F	PROVIDER OR SUPPLIER	;	STREET ADD	DRESS, CITY, S	STATE, ZIP CODE		
NEW DIA	MENSIONS INTERVEN	ITIONS INC	2856 AND	ERSON ROA	AD.		
INLAA DIN	MENSIONS INTERVEN	TIONS, INC	BURLING	TON, NC 27	217		
(X4) ID	_	TEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	NC	(X5)
PRÉFIX	`	MUST BE PRECEDED BY F		PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO		COMPLETE DATE
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG	DEFICIENCY)	PRIAIE	DAIL
					,		
V 133	G.S. 122C-80 Crim	inal History Record Ch	neck	V 133			
		IMINAL HISTORY RE	CORD				
	CHECK REQUIRE						
	APPLICANTS FOR						
		used in this section, the					
		o an area authority/cou	-				
		rovider of mental healt					
		bility, and substance a					
		nsable under Article 2	oi this				
	Chapter.	An offer of employmer	nt by a				
		nder this Chapter to ar					
		sition that does not re					
		n occupational license					
		sent to a State and na					
		ord check of the applic					
		een a resident of this S					
		, then the offer of emp					
	_	onsent to a State and i	-				
		ord check of the applic					
		story record check sha					
		he applicant's fingerpr					
		een a resident of this S					
	five years or more,	then the offer is condi-	tioned				
	on consent to a Sta	ite criminal history rec	ord				
		ant. A provider shall no					
		t who refuses to conse					
		ord check required by					
		otherwise provided in					
		ive business days of m					
		r of employment, a pro					
		est to the Department					
		114-19.10 to conduct					
		ord check required by					
		mit a request to a priv					
		State criminal history r					
		his section. Notwithsta					
		 Department of Justice f national criminal histo 					
	return the results of	mational criminal filst	וע y				

Division of Health Service Regulation STATE FORM

DIVISION	of Health Service Re	eguiation					
	NT OF DEFICIENCIES	(X1) PROVIDER/S			E CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATI	ON NUMBER:	A. BUILDING:		COMP	LETED
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NAME OF I			CTDEET AD	DDESS CITY O	TATE ZID CODE	_	
NAIVIE OF I	PROVIDER OR SUPPLIER				STATE, ZIP CODE		
NEW DIN	MENSIONS INTERVEN	ITIONS, INC		ERSON ROATON, NC 27			
				10N, NC 27			1
(X4) ID		TEMENT OF DEFICI		ID	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU		(X5) COMPLETE
PREFIX				PREFIX TAG	CROSS-REFERENCED TO THE APPRO		DATE
IAG	TAG REGULATORY OR LSC IDENTIFYING INFORMATION)			IAG	DEFICIENCY)		
	V400 0 0 0 5						
V 133	•			V 133			
	record checks for e						
	covered by Public L						
	Department of Hea						
	Criminal Records C						
	business days of re	•					
	history of the perso						
	and Human Service	•					
	Unit, shall notify the						
	information receive						
	of the applicant. In						
	national criminal his						
	with the provider. P upon request verific						
	check has been co						
	by this section. A co						
	appropriate local or						
	the Division of Crim						
	may conduct on be						
	criminal history rec						
	section without the						
	request to the Depa						
	case, the county sh	all commence	with the State				
	criminal history rec	ord check requi	red by this				
	section within five b	ousiness days o	f the				
	conditional offer of						
	All criminal history i						
	provider is confider						
	except to the applic						
	(c) of this section. F						
	subsection, the terr						
	business regularly						
	criminal history rec						
	records obtained from						
	(c) Action If an ap						
	record check revea						
	a relevant offense,						
	of the following fact	ors in determin	ing whether to				
	hire the applicant:						
	(1) The level and seriousness of the crime.						

Division of Health Service Regulation STATE FORM

	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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		MHL001-165	B. WING		02/1	3/2020
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
NEW DI	MENSIONS INTERVEN	ITIONS. INC	ERSON ROA			
BURLING			TON, NC 27			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROINT DEFICIENCY)	D BE	(X5) COMPLETE DATE
V 133	Continued From pa	ge 6	V 133			
V 133	(2) The date of the (3) The age of the proviction. (4) The circumstance commission of the (5) The nexus between the person and the filled. (6) The prison, jail, rehabilitation, and experson since the day (7) The subsequent a relevant offense. The fact of convictions that the provider disquence consideration of the provider may disclost the criminal history to the disqualification of the criminal history to the disqualification of the criminal history to the disqualification of the criminal history (2) Limited Immunition or employee of a procomplies with this scivil liability for: (1) The failure of the individual on the bath the criminal history (2) Failure to check criminal offenses if history record check compliance with this (e) Relevant Offense in federal criminal history indictment of a criminal history of the criminal history record check compliance with this indictment of a criminal history indictment of a criminal history of the criminal history record check criminal offense in federal criminal history record check criminal offense in federal criminal history record check criminal history record check criminal offense in federal criminal history record check criminal offense in federal criminal history record check criminal history record check criminal offense in federal criminal history record check criminal history record c	crime. Derson at the time of the describer of known. Deen the criminal conduct of job duties of the position to be probation, parole, employment records of the late the crime was committed. It commission by the person of the late the crime was committed. It commission by the person of the late the crime was committed. It commission by the provider. It commission by the provider. It considered by the provider. It is an applicant after the relevant factors, then the late information contained in the late information contained in the late of t	V 133			

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Division of Health Service Regulation STATE FORM

DIVISION	Division of Health Service Regulation						
	IT OF DEFICIENCIES	(X1) PROVIDER/S		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICAT	ION NUMBER:	A. BUILDING:		COMP	LLIED
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		MHL001-	165	B. WING		02/1	3/2020
NAME OF F	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
	2856 AN			ERSON RO			
NEW DIN	NEW DIMENSIONS INTERVENTIONS, INC BURLIN						
(X4) ID	SUMMARY STA	TEMENT OF DEFIC		ID	PROVIDER'S PLAN OF CORRECTI	ON	(X5)
PRÉFIX	(EACH DEFICIENCY	MUST BE PRECE	DED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL	D BE	COMPLETE
TAG REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG	CROSS-REFERENCED TO THE APPRO DEFICIENCY)	PRIATE	DATE	
					,		
V 133	Continued From pa	ge 7		V 133			
	have responsibility	for the safetv a	nd well-being of				
	persons needing m						
	disabilities, or subs						
	crimes include the	criminal offense	es set forth in				
	any of the following						
	General Statutes: A						
	Issuing Monetary S						
	Endangering Execu						
	Article 6, Homicide;						
	Sex Offenses; Artic						
	Kidnapping and About Injury or Damage b						
	Incendiary Device of						
	and Other Housebr						
	Other Burnings; Art						
	Robbery; Article 18		•				
	False Pretenses an						
	Obtaining Property	or Services by	False or				
	Fraudulent Use of 0						
	Article 19B, Financi						
	Act; Article 20, Frau						
	26, Offenses Again						
	Decency; Article 26						
	Article 27, Prostituti 29, Bribery; Article 3						
	Office; Article 35, O						
	Peace; Article 36A,						
	Article 39, Protection						
	Protection of the Fa						
	Intoxication; and Ar						
	Crime. These crime						
	sale of drugs in viol	ation of the No	rth Carolina				
	Controlled Substan	,	•				
	90 of the General S						
	offenses such as sa						
	violation of G.S. 18						
	impaired in violation	i of G.S. 20-13	8.1 through				
	G.S. 20-138.5.	shina Falsa Inf	formation - Δny				

Division of Health Service Regulation STATE FORM

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				(X3) DATE COMP	SURVEY PLETED		
						F	₹
		MHL001	-165	B. WING		02/1	13/2020
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2856 ANDERSON ROAD							
NEW DIN	NEW DIMENSIONS INTERVENTIONS INC			TON, NC 27			
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENCY REGULATORY OR L		DED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPROFICIENCY)	OULD BE	(X5) COMPLETE DATE
V 133	Continued From parapplicant for employenges, or otherwish an employment approximal history recessful be guilty of a (g) Conditional Employ an applican obtaining the result check regarding the following requirement (1) The provider shaprior to obtaining the criminal history recessful to the provider shaprior to a continuent cards as (2) The provider shapring the provider shapping the provider shapring the provider s	yment who will se gives false blication that is ord check und Class A1 mischoloyment Apt to conditionally sof a criminal e applicant if bents are met: all not employ e applicant's cord check as ris section or the required in Gall submit the ord check not the individual ment. (2000-194-124, ss. 10.	e information on a the basis for a er this section emeanor. Provider may prior to history record both of the an applicant consent for required in the completed and applicant for a later than five begins 54, s. 4; 19D(c), (h);	V 133			
	This Rule is not me Based on record re failed to assure a si records check and requested within fiv employment for 1 of findings are:	view and inter tate and natior fingerprint che e days of the o	view, the facility nal criminal eck was offer of				
Review on 2/13/20 of Staff #1's record revealed: - Hire date unavailable Employed as Habilitation Technician - Current Driver's License was from the state of Tennessee.							

Division of Health Service Regulation STATE FORM

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		
		MHL001-165		B. WING			R 12/2020
		WITILUU 1-165				02/	13/2020
NAME OF F	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
NEW DIN	MENSIONS INTERVEN	ITIONS, INC		ERSON ROATON, NC 27			
(X4) ID PREFIX		TEMENT OF DEFICIENCIE MUST BE PRECEDED B		ID PREFIX	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI		(X5) COMPLETE
TAG		SC IDENTIFYING INFORM		TAG	CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	DATE
V 133	Continued From pa	ge 9		V 133			
	- Criminal record ch did not include a na						
	Interview on 2/13/20 with the Staff on duty confirmed the above findings.						
V 736	27G .0303(c) Facilit	ty and Grounds Mai	ntenance	V 736			
	10A NCAC 27G .03 EXTERIOR REQUI (c) Each facility and maintained in a safe manner and shall b odor.	REMENTS I its grounds shall be e, clean, attractive a	e and orderly				
	This Rule is not me Based on observati failed to be maintain orderly manner. The	on and interviews, t ned in a safe, clean					
	Observation on 2/13 facility revealed the Bedroom to the left entry:	following:					
	 large area of the confidence of the ceiling was meaning. residue from the confidence areas of the stains as from a was meaning. 	nissing eiling was covering he ceiling had dark	the floor				
	area on ceiling ne- damp and protruding	ar fan was bulging,	appeared				
	During interview on - confirmed the abo - no client was curre	ve findings					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTIO A. BUILDING:	COMPLETED					
		R					
MHL001-165	B. WING	02/13/2020					
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
NEW DIMENSIONS INTERVENTIONS INC	ANDERSON ROAD LINGTON, NC 27217						
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	PREFIX (EACH CO	DER'S PLAN OF CORRECTION DRRECTIVE ACTION SHOULD BE FERENCED TO THE APPROPRIATE DATE DEFICIENCY) (X5) COMPLETE DATE					
V 736 Continued From page 10 roof leaks the building owner said she was selling/rentir the building, therefore they were planning to move to another location. This deficiency constitutes a re-cited deficience and must be corrected within 30 days							

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