PRINTED: 02/19/2021 FORM APPROVED

Division of	of Health Service Regu	ılation			FORW APPROVE	
STATEMENT	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	MHL036-342		B. WING		R 02/19/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE	•	
DI 00001	4 0044441111TV 0EDV/00	1911 W	ILLIMAX AVENUE			
BLOSSON	M COMMUNITY SERVICE	GASTO	NIA, NC 28054			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFIME DEFICIENCY)	D BE COMPLETE	Έ
V 000	INITIAL COMMENTS	3	V 000			
	on 2/19/21. The com (Intake #NC171933). This facility is license	w-up survey was completed plaint was unsubstantiated Deficiencies were cited. In the following service 27G .1700 Residential are for Children or				
V 108	27G .0202 (F-I) Pers	onnel Requirements	V 108			
	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,					

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

TITLE (X6) DATE

PRINTED: 02/19/2021 FORM APPROVED

Division of Health Service Regulation

T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION		(X3) DATE SURVEY	
OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMP	LETED	
					R	
	MHL036-342	B. WING			19/2021	
ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STA	TE, ZIP CODE			
	1911 WIL	LIMAX AVENUE				
M COMMUNITY SERVICE	S. INC					
SUMMARY ST	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN O	F CORRECTION	(X5)	
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO	CTION SHOULD BE THE APPROPRIATE	COMPLETE DATE	
Continued From page	e 1	V 108				
reporting, investigatir	ng and controlling infectious					
Based on record revifacility failed to ensur was available in the folient was present was cardiopulmonary resultering the maneuver of such as those provided American Heart Assofor relieving airway of #2, #3, #4), 1 of 1 Assorber	ews and interviews, the re at least one staff member facility at all times when a reas trained in basic first aid, ruscitation(CPR) and the rother first aid techniques red by Red Cross, the reciation or their equivalence restruction for 4 of 4 staff (#1, sociate Professional (AP)					
-staff #1 was hired or Direct Care Paraprof completed training in CPR Foundation date record; -staff #2 was hired or Direct Care Paraprof completed training in Today, Inc. dated 11/ record; -staff #3 was hired or Direct Care Paraprof completed training in Today, Inc. dated 11/ record;	n 11/1/20 with the job title of essional. A certification of CPR/First Aid with National ed 11/1/20 was present in the n 11/24/20 with the job title of essional. A certification of CPR/First Aid with CPR 30/20 was present in the n 9/30/20 with the job title of essional. A certification of CPR/First Aid with CPR 1/20 was present in the					
)	Continued From page reporting, investigating and communicable dients. This Rule is not met Based on record revifacility failed to ensur was available in the folient was present was cardiopulmonary resulte Heimlich maneuver of such as those provided American Heart Assofor relieving airway on #2, #3, #4), 1 of 1 As and 1 of 1 Qualified Findings are: Review on 2/4/21 of estaff #1 was hired on Direct Care Paraproficompleted training in CPR Foundation date record; estaff #2 was hired on Direct Care Paraproficompleted training in Today, Inc. dated 11/ record; estaff #3 was hired on Direct Care Paraproficompleted training in Today, Inc. dated 11/ record; estaff #3 was hired on Direct Care Paraproficompleted training in Today, Inc. dated 11/ record;	MHL036-342 PROVIDER OR SUPPLIER M COMMUNITY SERVICES, INC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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 record reviews and interviews, the facility failed to ensure at least one staff member was available in the facility at all times when a client was present was trained in basic first aid, cardiopulmonary resuscitation(CPR) and 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 for 4 of 4 staff (#1, #2, #3, #4), 1 of 1 Associate Professional (AP) and 1 of 1 Qualified Professional(QP). The findings are: Review on 2/4/21 of personnel records revealed: -staff #1 was hired on 11/1/20 with the job title of Direct Care Paraprofessional. A certification of completed training in CPR/First Aid with National CPR Foundation dated 11/1/20 was present in the record; -staff #2 was hired on 11/24/20 with the job title of Direct Care Paraprofessional. A certification of completed training in CPR/First Aid with CPR Today, Inc. dated 11/30/20 was present in the record; -staff #3 was hired on 9/30/20 with the job title of Direct Care Paraprofessional. A certification of completed training in CPR/First Aid with CPR Today, Inc. dated 11/1/20 was present in the record; -staff #3 was hired on 9/30/20 with the job title of Direct Care Paraprofessional. A certification of completed training in CPR/First Aid with CPR Today, Inc. dated 11/1/20 was present in the	MHL036-342 STREET ADDRESS, CITY, STA M COMMUNITY SERVICES, INC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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 record reviews and interviews, the facility failed to ensure at least one staff member was available in the facility at all times when a client was present was trained in basic first aid, cardiopulmonary resuscitation(CPR) and 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 for 4 of 4 staff (#1, #2, #3, #4), 1 of 1 Associate Professional (AP) and 1 of 1 Qualified Professional (QP). The findings are: Review on 2/4/21 of personnel records revealed: -staff #1 was hired on 11/1/20 with the job title of Direct Care Paraprofessional. A certification of completed training in CPR/First Aid with National CPR Foundation dated 11/1/20 was present in the record; -staff #2 was hired on 9/30/20 was present in the record; -staff #3 was hired on 9/30/20 with the job title of Direct Care Paraprofessional. A certification of completed training in CPR/First Aid with CPR Today, Inc. dated 11/30/20 was present in the record; -staff #3 was hired on 9/30/20 with the job title of Direct Care Paraprofessional. A certification of completed training in CPR/First Aid with CPR Today, Inc. dated 11/30/20 was present in the record;	A BUILDING: B. WING	MHL036-342 **ROWIDER OR SUPPLIER** **STREET ADDRESS, CITY, STATE, ZIP CODE** **MOMUNITY SERVICES, INC** **SUMMARY STATEMENT OF DEFICIENCIES** (EACH DEPICIENCY MUST BE PIECEDED BY PILL PRESULATORY OR IS SUMMARY STATEMENT OF DEFICIENCIES** (EACH DEPICIENCY MUST BE PIECEDED BY PILL PRESULATORY OR IS SUMMARY STATEMENT OF DEFICIENCIES** (EACH DEPICIENCY MUST BE PIECEDED BY PILL PRESULATORY OR IS SUMMARY STATEMENT OF DEFICIENCIES** (EACH DEPICIENCY MUST BE PIECEDED BY PILL PRESULATORY OR IS SUMMARY STATEMENT OF DEFICIENCY) **CONTINUED From page 1** **TAG** 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 record reviews and interviews, the facility failed to ensure at least one staff member was available in the facility at all times when a client was present was trained in basic first aid, cardiopulmonary resuscitation (CPR) and 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 for 4 of 4 staff (#1, #2, #3, #4), 1 of 1 Associate Professional (AP) and 1 of 1 Qualified Professional (AP) and 1 of 1 Qualified Professional (AP) and 1 of 1 Qualified Professional A certification of completed training in CPR/First Aid with CPR Today, Inc. dated 11/1/20 was present in the record; -staff #3 was hired on 9/30/20 with the job title of Direct Care Paraprofessional. A certification of completed training in CPR/First Aid with CPR Today, Inc. dated 11/1/20 was present in the record; -staff #4 was hired on 9/30/20 with the job title of Direct Care Paraprofessional. A certification of completed training in CPR/First Aid with CPR Today, Inc. dated 11/1/20 was present in the record; -staff #4 was hired on 9/30/20 with the job title of Direct Care Paraprofessional. A certification of completed training in CPR/First Aid with CPR Today, Inc. dated 11/1/20 was present in the	

Division of Health Service Regulation

STATE FORM 6899 NWPB11 If continuation sheet 2 of 8

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
ANDILAN	or connection	IDENTIFICATION NOMBER.	A. BUILDING: _	A. BUILDING:			
		MHL036-342	B. WING			२ 19/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STA	TE, ZIP CODE			
BLOSSOI	M COMMUNITY SERVICE	S. INC	ILLIMAX AVENUE NIA, NC 28054				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
V 108	completed training in CPR Foundation date the record; -the AP was hired on completed training in Today, Inc. dated 7/2 record; -the QP was hired on completed training in CPR Foundation date the record. Interview on 2/8/21 w-completed CPR/Firs-training was on-line. Interview on 2/8/21 w-completed CPR/Firs-someone came out t-also did some of the Attempted interviews 2/12/21 with staff #4 answered phone calls voicemail messages Interview on 2/18/21 -completed training in-someone came out a-some of the training Interview on 2/19/21 officer revealed:	essional. A certification of CPR/First Aid with National ed 11/30/20 was present in 7/23/20. A certification of CPR/First Aid with CPR 4/20 was present in the 11/5/20. A certification of CPR/First Aid with National ed 11/19/20 was present in with staff #1 revealed: t Aid training; with staff #2 revealed: t Aid training; with staff #3 revealed: t Aid; to do training; training on-line. on 2/8/21, 2/10/21 and were unsuccessful due to no and no response to left. with the AP revealed: the CPFR/First Aid; and did some training; was on-line. with the Chief Executive turriculum her staff had for	V 108	BCS will Hire a certified instructo and do the CPR training in perso			

Division of Health Service Regulation

STATE FORM 6899 NWPB11 If continuation sheet 3 of 8

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BOILDING.			R	
		MHL036-342	B. WING		02	/19/2021	
NAME OF P	ROVIDER OR SUPPLIER	STR	EET ADDRESS, CITY, STA	ATE, ZIP CODE			
DI 00001	A COMMUNITY OF DVICE	191	1 WILLIMAX AVENUE	I			
BLOSSON	I COMMUNITY SERVICE	GAS	STONIA, NC 28054				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
V 108	Continued From page	e 3	V 108				
	-will ensure her staff approved curriculums	complete CPR/First Aid in					
V 118	27G .0209 (C) Medic	ation Requirements	V 118				
	only be administered order of a person aut drugs. (2) Medications shall clients only when aut client's physician. (3) Medications, incluadministered only by unlicensed persons to the privileged to prepare (4) A Medication Admall drugs administere current. Medications recorded immediately MAR is to include the (A) client's name; (B) name, strength, a (C) instructions for ac (D) date and time the (E) name or initials of drug. (5) Client requests for checks shall be record autorial strength and the condense of the conde	istration: n-prescription drugs shall to a client on the written horized by law to prescribe be self-administered by horized in writing by the ding injections, shall be licensed persons, or by rained by a registered nurse egally qualified person and and administer medications ninistration Record (MAR) of d to each client must be kep administered shall be y after administration. The					

Division of Health Service Regulation

STATE FORM 6899 NWPB11 If continuation sheet 4 of 8

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING:		(X3) DATE SURVEY COMPLETED		
					R	
		MHL036-342	B. WING		02/19/2021	<u> </u>
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	E, ZIP CODE		
		1911 WI	LLIMAX AVENUE			
BLOSSO	M COMMUNITY SERVIC	ES. INC	NIA, NC 28054			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCED	TION SHOULD BE COMP THE APPROPRIATE DA	(5) PLETE ATE
V 118	Continued From pa	ge 4	V 118			
	interviews, the facility or non-prescription of client on the written by law to prescribe of client(#1). The finding Review on 1/28/21 of classification of the first of admission of the first of the f	eview, observations and ty failed to ensure prescription drugs were administered to a order of a person authorized drugs affecting 1 of 1 ngs are: of client #1's record revealed: 11/3/20; Traumatic Stress Disorder ressive Disorder and ity Disorder.				
	months of December February 2021 reversity and particular february 2021 reversity and particular february 2021; -Albuterol Sulfate H	er 2020, January 2021 and aled the following: ate (generic for Vistaril) 25 tablet four times a day as d as administered in the er 2020, January 2021 and				
	months of December-fluoxetine (generic the am documented December 2020 MA-Trazadone 50mg or documented as discumented as discumentation instilisted "C" as the coordination on the MAR	d as administered in the er 2020 and January 2021; for Prozac) 20mg on tablet in as discontinued on the LR on 12/6; ne and a half tablets at night continued on the December ructions on back of the MARs de for client being out of the s for the dosing dates when the facility and no "C" was in				

Division of Health Service Regulation

STATE FORM 6899 NWPB11 If continuation sheet 5 of 8

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED
			A BOILDING.		D.
		MHL036-342	B. WING		R 02/19/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE	
BLOSSON	I COMMUNITY SERVICE	S. INC	IMAX AVENUE A, NC 28054		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
V 118	medications on-site re-hydroxyzine pamoate mg(milligrams) one ta needed dispensed 10-Albuterol Sulfate HF/needed with expiratio-fluoxetine (generic for the am and Trazadon tablets at night not on tablets at night not allocal regarding the above I medications(hydroxyz Sulfate, fluoxetine and following information: amount, dosing instruphysician and date mphysician's signature; no discontinued sign fluoxetine 20mg on tate Trazadone 50mg one-print-out from a local 12/7/20 with the instru (generic for Prozac) 2 no physician's signature; her medications staff never forgets her went on home visits occassions including	21 at 10:10am of client #1's evealed: e (generic for Vistaril) 25 ablet four times a day as //26/20; A 90mcg(microgram) as n date of 4/2022; or Prozac) 20mg on tablet in e 50mg one and a half -site. 6/21 of client #1's record mental health provider isted cine pamoate, Albuterol d Trazadone) with the name of medication, ctions, name of prescribing edication prescribed but no ed physicians' orders for blet in the am and and a half tablets at night; health provider dated uctions to stop fluoxetine comg on tablet in the am but are. with client #1 revealed: in the morning and at night;	V 118	DEFICIENCY)	
	Executive Officer(CE) -not aware she had to	•			

Division of Health Service Regulation

STATE FORM 6899 NWPB11 If continuation sheet 6 of 8

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING:		COMPLE	IED
		MHL036-342	B. WING		R 02/19	9/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
BLOSSON	I COMMUNITY SERVICE	S. INC	IMAX AVENUE A, NC 28054			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
V 118	health agency when c -will ensure obtain all all medications admin	t from the local mental client #1 was admitted; signed physician orders for histered; pletely fill out dosing dates	V 118	AP/QP and nurse Will make ensure that upon beir our program our member will have physician orde coming into the program		
V 736	V 736 27G .0303(c) Facility and Grounds Maintenance 10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS (c) Each facility and its grounds shall be maintained in a safe, clean, attractive and orderly manner and shall be kept free from offensive odor.		V 736			
	safe, clean, attractive findings are: Observation on 2/16/2-vacant client bedroor large picture window round hole with two coplexiglas pane; -vacant client bedroor hallway on right had a on wall under switchpinches by twelve inchedity vent cover in ha	as, record review and was not maintained in a and orderly manner. The 21 at 10:05 am revealed: m #1 off dining room had a with an one inch by one inch racks near the bottom of the an unpainted patched area alate approximately five es;				

Division of Health Service Regulation

STATE FORM 6899 NWPB11 If continuation sheet 7 of 8

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED
		MHL036-342	B. WING		R 02/19/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
BLOSSO	M COMMUNITY SERVICE	S. INC	IMAX AVENUE A, NC 28054		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
V 736	hallway on left had ar located behind the be six inches by six inchealso in occupied clier dresser with missing obeeping smoke alarm. Interview on 2/16/21 of Officer(CEO) revealed not sure when hole holient #1 did not have will call a contractor is someone to replace the Review on 2/16/21 of 4:45pm from the CEO photo of the repaired	a unpainted patched area droom door approximately es; at bedroom #3 was 2 drawers; an. with the Chief Executive di: appened in window pane; access to this room; ammediately and get the broken window. an email sent on 2/16/21 at 0 revealed an attached window pane. tutes a re-cited deficiency	V 736	The walls have been painte. we have a house recontact the maintenance man if issues occur. Smoke detectors will go on our daily maintenance sure we are changing the batteries in a timely mathere is one drawer missing and will be removed. Window has been fixed	sheet to make nner

Division of Health Service Regulation

STATE FORM 6899 NWPB11 If continuation sheet 8 of 8