AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		MHL005-018	B. WING		10	0/06/2021
AME OF PF	ROVIDER OR SUPPLIER	STREETA	DDRESS, CITY, STATE	, ZIP CODE		
TEP(S	JMMIT TRAINING AND	EDUCATION PROGR	JRT STREET SON, NC 28640			
	SUMMARY ST		ID	PROVIDER'S PLAN OF		(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	COMPLET DATE
V 000	INITIAL COMMENTS	3	V 000			
	An annual and complaint survey was completed on 10/6/21. The complaint was unsubstantiated (NC00179061). Deficiencies were cited.					
		d for the following service 27G .5400 Day Activity for bility Groups.				
V 108	27G .0202 (F-I) Pers	onnel Requirements	V 108			
	(g) Employee trainin	tion shall be documented. g programs shall be nimum, shall consist of the				
	(2) training on clientdelineated in 10A NC10A NCAC 26B;	rights and confidentiality as CAC 27C, 27D, 27E, 27F and the mh/dd/sa needs of the				
		the treatment/habilitation ous diseases and				
	(h) Except as permitt .5602(b) of this Subc	ed under 10a NCAC 27G hapter, at least one staff ilable in the facility at all				
	member shall be train including seizure man to provide cardiopulm	ned in basic first aid nagement, currently trained nonary resuscitation and				
	techniques such as the American Heart A	h maneuver or other first aid nose provided by Red Cross, ssociation or their ving airway obstruction.				
	(i) The governing bo implement policies ar					

X5Q911

STATEMENT OF DEFICIENCIES (X ND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL005-018			10	/06/2021
AME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE		
TEP(S	UMMIT TRAINING AND	EDUCATION PROGR	SON, NC 28640			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLE ⁻ DATE
V 108	Continued From page 1		V 108			
	and communicable d clients.	iseases of personnel and				
	facility failed to ensur trained in cardiopulm	ews and interviews, the re that staff members were ionary resuscitation (CPR) 3 of 3 audited staff (Staff				
	Review on 9/17/21 o revealed: -hire date of 6/7/18; -CPR/First Aid certifio	f Staff #1's personnel record cation dated 5/22/20.				
	Review on 9/15/21 o revealed: -hire date of 3/5/07; -CPR/First Aid certific	f Staff #2's personnel record cation dated 4/1/21.				
	Review on 9/17/21 o (QP) personnel recor -hire date of 7/29/19; -CPR/First Aid certific					
	-the CPR/First Aid ce course; -due to the COVID-1	with the QP revealed: ertification was an online only 9 pandemic and restrictions, ands-on component to test				
	Review of email on 9 revealed: -due to Covid-19 any alth Service Regulation	/22/21 from the QP CPR/First Aid training in				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CC A. BUILDING:	(X3) DATE SURVEY COMPLETED			
			A. BUILDING.				
		MHL005-018	B. WING		10	/06/2021	
AME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	ZIP CODE			
TEP(S	UMMIT TRAINING AND	EDUCATION PROGE	IRT STREET SON, NC 28640				
(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 ACTI CROSS-REFERENCED TO T	ON SHOULD BE	(X5) COMPLET DATE	
				DEFICIENC	Y)		
V 108	Continued From page	e 2	V 108				
	hands-on componen COVID transmission	cent CPR/First Aid class was ency and included a					
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, inclu administered only by unlicensed persons t pharmacist or other li- privileged to prepare (4) A Medication Adm all drugs administere current. Medications recorded immediately MAR is to include the (A) client's name; (B) name, strength, au (C) instructions for au (D) date and time the (E) name or initials of drug. (5) Client requests for checks shall be record 	n-prescription drugs shall to a client on the written horized by law to prescribe be self-administered by horized in writing by the uding injections, shall be licensed persons, or by rained by a registered nurse, egally qualified person and and administer medications. hinistration Record (MAR) of d to each client must be kept administered shall be y after administration. The					

STATE FORM

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X5Q911

If continuation sheet 3 of 5

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) I A. BUILDING:			
		MHL005-018			10	/06/2021	
AME OF PF	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE JRT STREET	, ZIP CODE			
TEP(S	UMMIT TRAINING AND	EDUCATION PROGR	SON, NC 28640				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES DY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A) CROSS-REFERENCED TO DEFICIE!	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLET DATE	
V 118	Continued From pag	e 3	V 118				
	medications were red	iews, interviews and ility failed to ensure that corded immediately after ng 1 of 4 audited clients					
	-date of admission w -diagnoses of Anxiety Moderate Intellectual Cerebral Palsy, Seiz	y/Depressive symptoms, l/Developmental disability, ure Disorder, Hydrocephalus ncontinence, Sensory isomnia, Seborrhea					
	-Baclofen 10 milligra	f Client #1's MAR revealed: ms take 3 tablets by mouth dered 2/7/21 for muscle					
	revealed: -Non-audited Staff #4	rview at 11:20 on 9/17/21 4 entered the staff office and					
	given Client #1's 12:0 -she was leaving soc	already initialed that she had 00 pm dose of Baclofen. on, would not be at the facility eded to mark out her initials d initial after they					
	Interview on 9/22/21						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
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AME OF PF	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE			
TEP (S	UMMIT TRAINING AND	FDUCATION PROGE	JRT STREET			
(0		JEFFER	SON, NC 28640			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 118	Continued From pag	le 4	V 118			
	revealed:					
	-she checks MARS r					
		ot of missing initials on the				
	Professional (QP) at	alked to the Qualified				
		sing initials, she "tracks down				
	staff person" to initia	I MAR;				
		t of reminders" and now				
		ow the medicine cabinet; he knew if a medication had				
	been administered, t					
		very good question."				
	medication administr	accurately document				
		received their medications				
	as ordered by the ph	iysician.				
on of Hea	alth Service Regulation					