NC DEPARTMENT OF
HEALTH AND
HUMAN SERVICES

ROY COOPER • Governor
KODY H. KINSLEY • Secretary
MARK PAYNE • Director, Division of Health Service Regulation

January 5, 2022

Ms. Kellie Hardison, Director
Country Living Guest Home, Inc.
3094 Market Street Extension
Washington, NC 27889

Re: Annual and Follow Up Survey completed December 15, 2021
Country Living Guest Home, 3094 Market Street Extension, Washington, NC, 27889
MHL # 007-032
E-mail Address: countrylivinginc@yahoo.com

Dear Ms. Hardison:

Thank you for the cooperation and courtesy extended during the annual and follow up survey completed 12/15/21.

As a result of the follow up survey, it was determined that all of the deficiencies are now in compliance, which is reflected on the enclosed Revisit Report. Additional deficiencies were cited during the survey.

Enclosed you will find all deficiencies cited listed on the Statement of Deficiencies Form. The purpose of the Statement of Deficiencies is to provide you with specific details of the practice that does not comply with state regulations. You must develop one Plan of Correction that addresses each deficiency listed on the State Form, and return it to our office within ten days of receipt of this letter. Below you will find details of the type of deficiencies found, the time frames for compliance plus what to include in the Plan of Correction.

Type of Deficiencies Found

- Standard level deficiency.

Time Frames for Compliance

- Standard level deficiency must be ***corrected*** within 60 days from the exit of the survey, which is February 13, 2022.

What to include in the Plan of Correction

- Indicate what measures will be put in place to ***correct*** the deficient area of practice (i.e. changes in policy and procedure, staff training, changes in staffing patterns, etc.).
- Indicate what measures will be put in place to ***prevent*** the problem from occurring again.
- Indicate ***who will monitor*** the situation to ensure it will not occur again.
- Indicate ***how often*** the monitoring will take place.
- Sign and date the bottom of the first page of the State Form.

Make a copy of the Statement of Deficiencies with the Plan of Correction to retain for your records.
Please do not include confidential information in your plan of correction and please remember never to send confidential information (protected health information) via email.

Send the original completed form to our office at the following address within 10 days of receipt of this letter.

Mental Health Licensure and Certification Section
NC Division of Health Service Regulation
2718 Mail Service Center
Raleigh, NC 27699-2718

A follow up visit will be conducted to verify all violations have been corrected. If we can be of further assistance, please call Ms. Gloria Locklear, Team Leader at (910) 214-0350.

Sincerely,

Latisha Grant

Latisha Grant
Facility Compliance Consultant I
Mental Health Licensure & Certification Section

Cc: Leza Wainwright, Director, Trillium Health Resources LME/MCO
Fonda Gonzales, Interim Quality Management Director, Trillium Health Resources LME/MCO
Pam Pridgen, Administrative Assistant

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL007-032	A. BUILDING: _____ B. WING _____	R 12/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY LIVING GUEST HOME	3094 MARKET STREET EXTENSION WASHINGTON, NC 27889

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 000	INITIAL COMMENTS An annual and follow up survey was completed on December 15, 2021. A deficiency was cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities. The survey sample consisted of audits of 3 current clients.	V 000		
V 108	27G .0202 (F-I) Personnel Requirements 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	V 108	V108 Personnel Requirements CPR/First Aid and NCI training was conducted in-person on 1/5/22 and 1/10/22. The training was conducted by Bernadine Freeman and every employee of the agency attended. In the future, all CPR/First Aid will be provided in-person. The LCSW/Administrator/DP will monitor trainings on a monthly basis. The LCSW/Administrator/DP utilizes a chart to ensure all required trainings are up-to-date.	1/5/22 1/10/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jeffrey Bell | TITLE: RN/DP | (X6) DATE: 1/14/22

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V 108	Continued From page 1 implement policies and procedures for identifying, reporting, investigating and controlling infectious and communicable diseases of personnel and clients. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure staff were trained in Cardiopulmonary Resuscitation (CPR) and First Aid affecting 2 of 3 staff audited (#1 and #2). Review on 12/14/21 of staff #1's personnel record revealed: -A re-hire date of 12/28/18. -National CPR Foundation training certificate dated 7/18/21 for CPR and first aid. -There was no evidence of a current CPR or First Aid Certification that had been conducted with an in-person instructor. Review on 12/14/21 of staff #2's personnel record revealed: -A hire date of 8/3/21. -National CPR Foundation training certificate dated 7/21/21 for CPR and first aid. -There was no evidence of a current CPR or First Aid Certification that had been conducted with an in-person instructor. Interview on 12/14/21 staff #1 stated: -She came back to work at the facility in 2018. -She had completed trainings that included CPR and First Aid. -Her CPR and First Aid Training had been completed on-line.	V 108		

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V 108	Continued From page 2 Interview on 12/13/21 staff #2 stated: -He had worked at the facility for 6 months. -He had completed trainings that included CPR and First Aid, Medication Administration, and diabetes trainings. Interview on 12/14/21 the Qualified Professional/RN stated: -The National CPR Foundation training was an online training that was provided to staff because of the on-going pandemic. -He would ensure future CPR and First Aid training provided to staff was with an in-person instructor.	V 108		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
MHL007-032	A. Building B. Wing	12/15/2021

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY LIVING GUEST HOME	3094 MARKET STREET EXTENSION WASHINGTON, NC 27889

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix V0105 Reg. # 27G .0201 (A) (1-7) LSC	Correction Completed 12/15/2021	ID Prefix V0364 Reg. # G.S. 122C- 62 LSC	Correction Completed 12/15/2021	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR Latisha Grant	DATE 12/15/21
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 11/5/2020	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			