STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ` '			(X3) DATE SURVEY COMPLETED		
ANDILAN	OF CONTROL OF THE CON	BENTI TOATION NOMBER.	A. BUILDING:	A. BUILDING:			
		MHL096-115	B. WING		03/2	२ 2 <mark>9/2022</mark>	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
COUNTE	RY PINES #2		TH BESTON				
300.111		LA GRAN	GE, NC 285	51			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE	
V 000	INITIAL COMMENT	rs .	V 000				
		w up survey was completed Deficiencies were cited.					
	category: 10A NCA	sed for the following service AC 27G .5600C Supervised h Developmental Disabilities.					
		sed for 5 and has a current urvey sample consisted of clients.					
V 118	27G .0209 (C) Med	ication Requirements	V 118				
	only be administered order of a person a drugs. (2) Medications shat clients only when a client's physician. (3) Medications, included administered only bunlicensed persons pharmacist or other privileged to prepare (4) A Medication Adall drugs administer current. Medication recorded immediated MAR is to include the (A) client's name; (B) name, strength, (C) instructions for (D) date and time the	inistration: non-prescription drugs shall ad to a client on the written uthorized by law to prescribe all be self-administered by uthorized in writing by the cluding injections, shall be by licensed persons, or by trained by a registered nurse, legally qualified person and e and administer medications. Iministration Record (MAR) of red to each client must be kept administered shall be ely after administration. The					

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:		, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED		
			A. BUILDING:			R	
		MHL096-115	B. WING	· · · · · · · · · · · · · · · · · · ·		9/2022	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
COUNTR	RY PINES #2		RTH BESTON IGE, NC 285				
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
V 118	(5) Client requests checks shall be rec	for medication changes or corded and kept with the MAR appointment or consultation	V 118				
	Based on record re interview the facility medications as ord 3 audited clients (#	eview, observation and y failed to administer ered by the Physician for 2 of 3 and #4) and to keep the of 3 audited clients (#4). The					
	- 26 year old male a - Diagnoses include Intellectual/Develop Intermittent Explosicontrol; borderline I - Physician's orders 7/22/21 risperidone (mg) 1 tablet twice 10/21/21 benztropii twice daily	ed Autistic Disorder; comental Disability, moderate; cive Disorder; poor impulse hypertension; and obesity. s signed and dated as follows: e (anti-psychotic) 2 milligrams daily ne (anti-tremor) 2 mg 1 tablet a (anti-convulsant) 300 mg 1					
		home visit at the time of the and his medications were not vation.					
	January - March 20	of client #3's MARs for 022 revealed: isperidone 2 mg 1 tablet twice					

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STATE FORM 54B411 If continuation sheet 2 of 14

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE	SURVEY LETED
AND PLAN	OF CORRECTION	IDENTIFICATION NOMBER.	A. BUILDING:	 _	COMP	LETED
		MHL096-115	B. WING		03/2	₹ 9/2022
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
COUNT	N DINEC #2	2600 NOR	TH BESTON	I ROAD		
COUNTR	RY PINES #2	LA GRAN	GE, NC 285	51		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
V 118	daily; given at 8:00 - Blanks for risperior with "med (medicat 3/14/22 8:00 am wiexplanation Transcription for bedaily; given at 8:00 - Blanks for benztro am with "re-issued - Transcription for gat bedtime Blanks for gabaped documented expland documented expland During interview on took his medication and to his knowledged. Review on 3/25/22 - 33 year old male as Diagnoses included Disability, mild; Spin ventriculoperitonean neurogenic bowel as Physician's orders 2/10/21 Adult Gumis swallow 1 gummy of	am and 8:00 pm. Idone 3/08/22 8:00 am - 3/12/22 Idone 3/08/22 8:00 am - 3/12/22 Idone 3/08/22 8:00 am - 3/12/22 Idone 3/08/22 am 1 tablet twice Idone 3/08/22 - 3/14/22 8:00 Idone 3/08/22 - 3	V 118			
	day. Review on 3/25/22 January 2022 - Mar - Transcription for 0 given at 8:00 am The transcription was drawn through January 2022 - Mar	of client #4's MARs for rch 2022 revealed: Centrum tablet 1 tablet daily; was crossed out and a line the boxes for staff initials				
		arv 2022 - March 2022.				

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MHL096-115 B. WING	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED	
COUNTRY PINES #2 2600 NORTH BESTON ROAD LA GRANGE, NC 28551 (A4) III SUMMARY STATEMENT OF DEFICIENCIES III PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG TAG CROSS-REFERENCE ACTION SHOULD BE CROSS-REFERENCE ACTION CHOULD BE CROSS-REFERENCE OF OTHE APPROPRIATE DEFICIENCY) V 118 Continued From page 3 V 118 Observation on 3/25/22 at approximately 2:15 pm of client #4's medications on hand revealed: - Over the counter bottle of adult gummy chewable multivitamins with pharmacy label that included chew and swallow 2 gummy daily, dispensed 3/15/22. During interview on 3/29/22 client #4 stated he took his medications daily with staff assistance. He did not know the names of his medications, but he got "some gummies every day." During interview on 3/25/22 staff #4 stated one of her responsibilities was to administer medications; medications were always available. Medication changes were communicated to staff verbally and in writing. During interview on 3/29/22 staff #5 stated she did not often administer medications because there was a live-in staff at the facility. As far as she knew medications were always available. During interview on 3/29/22 Administrative Assistant #2 stated she understood the requirement for MARs to be kept current and to reflect medication orders as written by the Physician. She was not sure why there were			MHL096-115	B. WING			
LA GRANGE, NC 28551 (XA) ID (NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	•	
PRÉFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) V 118 Continued From page 3 Observation on 3/25/22 at approximately 2:15 pm of client #4's medications on hand revealed: - Over the counter bottle of adult gummy chewable multivitamins with pharmacy label that included chew and swallow 2 gummy daily, dispensed 3/15/22. During interview on 3/29/22 client #4 stated he took his medications adily with staff assistance. He did not know the names of his medications, but he got "some gummies every day." During interview on 3/25/22 staff #4 stated one of her responsibilities was to administer medications; medications were always available. Medication changes were communicated to staff verbally and in writing. During interview on 3/29/22 staff #5 stated she did not often administer medications because there was a live-in staff at the facility. As far as she knew medications were always available. During interview on 3/29/22 Administrative Assistant #2 stated she understood the requirement for MARs to be kept current and to reflect medication orders as written by the Physician. She was not sure why there were	COUNTR	RY PINES #2					
Observation on 3/25/22 at approximately 2:15 pm of client #4's medications on hand revealed: - Over the counter bottle of adult gummy chewable multivitamins with pharmacy label that included chew and swallow 2 gummy daily, dispensed 3/15/22. During interview on 3/29/22 client #4 stated he took his medications daily with staff assistance. He did not know the names of his medications, but he got "some gummies every day." During interview on 3/25/22 staff #4 stated one of her responsibilities was to administer medications; medications were always available. Medication changes were communicated to staff verbally and in writing. During interview on 3/29/22 staff #5 stated she did not often administer medications because there was a live-in staff at the facility. As far as she knew medications were always available. During interview on 3/29/22 Administrative Assistant #2 stated she understood the requirement for MARs to be kept current and to reflect medication orders as written by the Physician. She was not sure why there were	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR	JLD BE	COMPLETE
Due to the failure to accurately document medication administration it could not be determined if clients received their medications as ordered by the physician. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 118	Observation on 3/2 of client #4's medic - Over the counter I chewable multivitar included chew and dispensed 3/15/22. During interview on took his medication He did not know the but he got "some got During interview on her responsibilities medications; medic Medication changes verbally and in writing During interview on did not often administere was a live-in significant with the shew medication of the puring interview on Assistant #2 stated requirement for MA reflect medication of Physician. She was blanks on the MAR. Due to the failure to medication administing determined if clients as ordered by the puring deficiency con This deficiency con	5/22 at approximately 2:15 pm ations on hand revealed: bottle of adult gummy mins with pharmacy label that swallow 2 gummy daily, 3/29/22 client #4 stated he stated one of his medications, ammies every day." 3/25/22 staff #4 stated one of was to administer ations were always available. It is were communicated to staffing. 3/29/22 staff #5 stated she ister medications because staff at the facility. As far as one were always available. 3/29/22 Administrative she understood the Rs to be kept current and to orders as written by the is not sure why there were so accurately document tration it could not be a received their medications hysician. Stitutes a re-cited deficiency	V 118			

Division of Health Service Regulation STATE FORM

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Division of Health Service Regulation			ī			
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
					R	
		MHL096-115	B. WING		03/2	9/2022
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
			TH BESTON			
COUNTR	Y PINES #2		GE, NC 285			
(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 APPROFIDERICIENCY)	D BE	(X5) COMPLETE DATE
V 120	Continued From pa	ge 4	V 120			
V 120	27G .0209 (E) Med	ication Requirements	V 120			
	well-lighted, ventilat and 86 degrees Fal (B) in a refrigerator, degrees and 46 degreeringerator is used shall be kept in a seor container; (C) separately for e (D) separately for e (E) in a secure mar for a client to self-m (2) Each facility that controlled substance registered under the	age: hall be stored: cked cabinet in a clean, ted room between 59 degrees hrenheit; , if required, between 36 grees Fahrenheit. If the for food items, medications eparate, locked compartment ach client; xternal and internal use; ner if approved by a physician hedicate. t maintains stocks of les shall be currently le North Carolina Controlled S. 90, Article 5, including any				
	interviews the facilit were stored secure (#3) and to keep re	views, observations and by failed to ensure medications ly for 1 of 3 audited clients frigerated medication in a entainer for 1 of 3 audited				
	- 26 year old male a- Diagnoses include					

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
			A. BUILDING:			Б	
		MHL096-115	B. WING		03/2	9/2022	
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
COUNTR	Y PINES #2		TH BESTON				
	011111111111111111111111111111111111111		GE, NC 285		011		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
V 120	Continued From pa	ge 5	V 120				
	Intermittent Explosicontrol; borderline has polyethylene glycol in 8 ounces of liquid Review on 3/25/22 - 33 year old male aborder polyethylene glycol in 8 ounces of liquid Review on 3/25/22 - 33 year old male aborder place and place aborder place in a place and pla	ve Disorder; poor impulse hypertension; and obesity. signed and dated 6/17/21 for (PEG) (laxative) mix 17 grams d and drink daily. of client #4's record revealed: admitted 4/01/08. ed Intellectual/Developmental na Bifida; Hydrocephalus with I shunt; seizures; and and bladder. signed and dated 6/10/21 for bry 10 mg insert 1 suppository 1/25/22 at approximately 2:25 ith pharmacy label for client #3 in the outside of the locked eliving room. In of suppositories with client #4 on shelf in facility					
	another staff left the medicine cart Client #3 was on a send the PEG hom would not give it to - Client #4's suppose	e PEG on the outside of the a home visit and staff did not e with him because his parent					
V 131	G.S. 131E-256 (D2 Verification) HCPR - Prior Employment	V 131				

Division of Health Service Regulation

STATE FORM 54B411 If continuation sheet 6 of 14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION		E SURVEY PLETED	
		MHL096-115	B. WING			R 29/2022
	PROVIDER OR SUPPLIER	2600 NO	DDRESS, CITY, S'RTH BESTON	ROAD		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
V 131	REGISTRY (d2) Before hiring h health care facility of health care facility of Personnel Registry	ge 6 EALTH CARE PERSONNEL ealth care personnel into a or service, every employer at a shall access the Health Care and shall note each incident oropriate business files.	V 131			
	failed to complete H Registry (HCPR) ch audited staff (#2). Review on 3/25/22 revealed:	view and interview the facility Health Care Personnel necks prior to hire for 1 of 3. The findings are: of staff #2's personnel record 1, title Paraprofessional.				
	Assistant #2 stated done before hire, he	3/29/22 Administrative HCPR checks were typically owever staff #2's was done sure all HCPR checks were bing forward.				
V 133	G.S. §122C-80 CR CHECK REQUIRE APPLICANTS FOR (a) Definition As u		V 133			

Division of Health Service Regulation

STATE FORM 54B411 If continuation sheet 7 of 14

DIVISION	of Health Service Re	guiation				
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
					_	,
			B. WING		F	
		MHL096-115	B. WING	·····	03/2	9/2022
NAME OF E	PROVIDER OR SUPPLIER	STREET AD	DRESS CITY S	STATE, ZIP CODE		
10 4012 01 1	NOVIDEN ON CONTENEN			,		
COUNTR	Y PINES #2		RTH BESTON			
		LA GRAN	GE, NC 285	51		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	NC	(X5)
PRÉFIX		MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL		COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO DEFICIENCY)	PRIATE	DATE
				BEI IOIENOT)		
V 133	Continued From pa	ge 7	V 133			
	•					
		rovider of mental health,				
		bility, and substance abuse				
	services that is lice	nsable under Article 2 of this				
	Chapter.					
	(b) Requirement A	An offer of employment by a				
	provider licensed un	nder this Chapter to an				
	applicant to fill a po	sition that does not require the				
		n occupational license is				
	• •	sent to a State and national				
		ord check of the applicant. If				
	_	een a resident of this State for				
		, then the offer of employment				
		onsent to a State and national				
		ord check of the applicant. The				
		story record check shall				
		the applicant's fingerprints. If				
		een a resident of this State for				
		then the offer is conditioned				
		te criminal history record				
		ant. A provider shall not				
		t who refuses to consent to a				
		ord check required by this				
		otherwise provided in this				
		ive business days of making				
		r of employment, a provider				
		est to the Department of				
	Justice under G.S.	114-19.10 to conduct a				
	criminal history reco	ord check required by this				
	section or shall sub	mit a request to a private				
		State criminal history record				
		his section. Notwithstanding				
		Department of Justice shall				
		f national criminal history				
		mployment positions not				
	covered by Public L					
		Ith and Human Services,				
		Check Unit. Within five				
		ceipt of the national criminal				
	mistory of the perso	n, the Department of Health				

DIVISION	of Health Service Re	egulation				
	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
					F	
		MHL096-115	B. WING			29/2022
		MHE090-115			03/2	3/2022
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
COLINITE	N/ DINIEG #6	2600 NOR	TH BESTON	I ROAD		
COUNTR	RY PINES #2	LA GRAN	GE, NC 285	51		
(X4) ID	SHMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTI	N	(X5)
PREFIX		MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL		COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO	PRIATE	DATE
				DEFICIENCY)		
V 133	Continued From pa	ne 8	V 133			
		-				
		es, Criminal Records Check				
		provider as to whether the				
		d may affect the employability				
		no case shall the results of the				
		story record check be shared				
	•	roviders shall make available				
		cation that a criminal history				
		mpleted on any staff covered				
		ounty that has adopted an				
		dinance and has access to				
		inal Information data bank				
		half of a provider a State				
		ord check required by this				
		provider having to submit a				
		artment of Justice. In such a				
		all commence with the State				
		ord check required by this				
		ousiness days of the				
		employment by the provider.				
		nformation received by the				
		itial and may not be disclosed,				
		ant as provided in subsection				
	(c) of this section. F					
		n "private entity" means a				
		engaged in conducting				
		ord checks utilizing public				
	records obtained fro					
		oplicant's criminal history				
		Is one or more convictions of				
		the provider shall consider all				
		ors in determining whether to				
	hire the applicant:					
		eriousness of the crime.				
	(2) The date of the					
		person at the time of the				
	conviction.					
		ces surrounding the				
	commission of the					
	(5) The nexus betw	een the criminal conduct of				

	Of Fleatin Service IN				ı	
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
					F	,
		MHL096-115	B. WING			9/2022
		III112000-110			03/2	.5/2022
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
COUNTE	RY PINES #2	2600 NOR	TH BESTON	I ROAD		
COUNTIN	TINLS #2	LA GRAN	GE, NC 285	51		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON	(X5)
PRÉFIX	•	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL		COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROI DEFICIENCY)	PRIAIE	DATE
V 133	Continued From pa	ge 9	V 133			
	the person and the	job duties of the position to be				
	filled.	,				
	(6) The prison, jail,	probation, parole,				
		mployment records of the				
		te the crime was committed.				
	(7) The subsequent	commission by the person of				
	a relevant offense.					
		on of a relevant offense alone				
		employment; however, the				
		be considered by the provider.				
		ıalifies an applicant after				
		e relevant factors, then the				
		se information contained in				
		record check that is relevant				
		on, but may not provide a copy				
		ry record check to the				
	applicant.					
		y A provider and an officer				
		ovider that, in good faith,				
		ection shall be immune from				
	civil liability for:	o provider to employ en				
		e provider to employ an sis of information provided in				
		record check of the individual.				
		an employee's history of				
		the employee's criminal				
		k is requested and received in				
	compliance with this	•				
		e As used in this section,				
		neans a county, state, or				
		ory of conviction or pending				
		ie, whether a misdemeanor or				
		pon an individual's fitness to				
		for the safety and well-being of				
		ental health, developmental				
		tance abuse services. These				
		criminal offenses set forth in				
	any of the following	Articles of Chapter 14 of the				
		article 5, Counterfeiting and				

A. BUILDING: MHI 096-115 B. WING	R 03/29/2022
MHI 096-115 B. WING	
MHL096-115 B. WING	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
COUNTRY PINES #2 2600 NORTH BESTON ROAD	
LA GRANGE, NC 28551	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BY THE APPROPRIMENT OF TH	BE COMPLETE
V 133 Continued From page 10 V 133	
Issuing Monetary Substitutes; Article 5A, Endangering Executive and Legislative Officers; Article 6, Homicide; Article 7A, Rape and Other Sex Offenses; Article 8, Assaults; Article 10, Kidnapping and Abduction; Article 13, Malicious Injury or Damage by Use of Explosive or Incendiary Device or Material; Article 14, Burglary and Other Housebreakings; Article 15, Arson and Other Burnings; Article 16, Larceny; Article 17, Robbery; Article 18, Embezzlement; Article 19, False Pretenses and Cheats; Article 19A, Obtaining Property or Services by False or Fraudulent Use of Credit Device or Other Means; Article 19B, Financial Transaction Card Crime Act; Article 29, Frauds; Article 21, Forgery; Article 26, Offenses Against Public Morality and Decency; Article 28A, Adult Establishments; Article 27, Prostitution; Article 28, Perjury; Article 29, Bribery; Article 31, Misconduct in Public Office; Article 36A, Riots and Civil Disorders; Article 39, Protection of Minors; Article 40, Protection of the Family; Article 59, Public Intoxication; and Article 60, Computer-Related Crime. These crimes also include possession or sale of drugs in violation of the North Carolina Controlled Substances Act, Article 5 of Chapter 90 of the General Statutes, and alcohol-related offenses such as sale to underage persons in violation of G.S. 18B-302 or driving while impaired in violation of G.S. 20-138.1 through G.S. 20-138.5. (f) Penalty for Furnishing False Information on an employment application that is the basis for a criminal history record check under this section shall be guilty of a Class A1 misdemeanor.	

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION (X3		SURVEY LETED
		MHL096-115	B. WING		F 03/2	R 9/2022
NAME OF F	PROVIDER OR SUPPLIER		DRESS CITY S	STATE, ZIP CODE	1 00/2	JIZUZZ
			TH BESTON			
COUNTR	Y PINES #2	LA GRAN	GE, NC 285	51		
(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 APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
V 133	obtaining the result check regarding the following requirement	t conditionally prior to s of a criminal history record e applicant if both of the ents are met:	V 133			
	prior to obtaining the criminal history reconsubsection (b) of the fingerprint cards as (2) The provider shoriminal history reconsultations.	all not employ an applicant e applicant's consent for ord check as required in is section or the completed required in G.S. 114-19.10. all submit the request for a ord check not later than five				
	conditional employr 2001-155, s. 1; 200	ment. (2000-154, s. 4; 4-124, ss. 10.19D(c), (h); 4, 5(a); 2007-444, s. 3.)				
	facility failed to requ checks within five b	et as evidenced by: views and interviews the uest state criminal background usiness days of employment aff (#2). The findings are:				
	revealed: - Hire date 12/02/2 - Consent for crimir 12/28/21.	of staff #2's personnel record I, title Paraprofessional. hal background check signed and check ordered 12/13/21.				
	Assistant #2 stated typically done before	3/29/22 Administrative criminal record checks were e hire, however staff #2's was ld ensure background checks hire going forward.				

Division of Health Service Regulation											
		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED						
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED					
					F	₹					
MHL096-115		B. WING		03/29/2022							
NAME OF E	DROVIDED OD SLIDDLIED	STREET AN	·								
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2000 NORTH RESTON BOAD											
COUNTRY PINES #2 2600 NORTH BESTON ROAD LA GRANGE, NC 28551											
			·								
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE					
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROP		DATE					
				DEFICIENCY)							
V 736	Continued From page 12		V 736								
	Continued From page 12										
V 736	27G .0303(c) Facility and Grounds Maintenance		V 736								
		03 LOCATION AND									
	EXTERIOR REQUI										
		l its grounds shall be e, clean, attractive and orderly									
		e kept free from offensive									
	odor.	o Kopt noo nom ononoivo									
	This Rule is not met as evidenced by:										
	Based on observation and interview the facility was not maintained in a safe and clean manner.										
	The findings are:										
	Observation of the facility 3/25/22 between 1:35										
	pm and 2:15 pm revealed:										
	- The inside of the microwave had rusty areas,										
		oor had a rusty area with a									
	hole.	·									
		e end kitchen cabinet over the									
	toaster oven.										
		in the hall bathroom would not									
	stay closed.	in the hellway									
		e in the hallway was rusty.									
		ares on client #4's bedroom with an area of the wooden									
	sub-floor exposed.	with all area of the woodell									
		fan blades were dusty.									
	•	inoleum floor covering in client									
		worn and scratched.									
		the ceiling fan in client #2 and									
	client #3's bedroom										
	_	ides in the living room were									
	dusty.										
	- The water tempera	ature in the hall bathroom sink									

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMF	(X3) DATE SURVEY COMPLETED					
		MHL096-115	B. WING			₹ !9/2022					
NAME OF PROVIDER OR SUPPLIER COUNTRY PINES #2 STREET ADDRESS, CITY, STATE, ZIP CODE 2600 NORTH BESTON ROAD LA GRANGE, NC 28551											
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE					
V 736	and in the sink in th #2 and #3 was 120 During interviews o Administrative Assic client #2 and #3's b She would have the down. She was aw	ge 13 e bathroom shared by clients degrees Fahrenheit. n 3/25/22 and 3/29/22 stant #1 stated the light in edroom would not turn on. water temperature turned are of the requirement for the ned in a safe and clean	V 736								