STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL084-098			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		B. WING		03/10/2022		
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE, ZIP CODE			
NEW LON	DON GROUP HOME		IGHWAY 740 NDON, NC 28127			
(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) COMPLET DATE
V 000	INITIAL COMMENTS		V 000			
	An annual survey was completed on March 10, 2022. Deficiency cited.					
	This facility is licensed for the following service category: 10A NCAC 27G. 5600C Supervised Living for Adults with Developmental Disabilities					
	The survey sample c current clients.	onsisted of audits of 3				
V 105	27G .0201 (A) (1-7) Governing Body Policies		V 105			
	POLICIES (a) The governing bo facility or service sha written policies for the (1) delegation of mar operation of the facili (2) criteria for admiss (3) criteria for dischar (4) admission assess (A) who will perform the (B) time frames for ca (5) client record man (A) persons authorized (B) transporting record (C) safeguard of record defacement or use by (D) assurance of record authorized users at a (E) assurance of con (6) screenings, which (A) an assessment of problem or need; (B) an assessment of	hagement authority for the ty and services; sion; rge; sments, including: the assessment; and completing assessment. agement, including: ed to document; rds; ords against loss, tampering, y unauthorized persons; ord accessibility to ill times; and fidentiality of records.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL084-098						(X3) DATE SURVEY COMPLETED	
		NUL 004 000					
				03	03/10/2022		
NAIVIE OF P	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE	, ZIP CODE			
NEW LON	IDON GROUP HOME		ONDON, NC 28127				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OI (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	ACTION SHOULD BE CC		
V 105	Continued From page 1		V 105				
ision of He	recommendations; (7) quality assurance activities, including: (A) composition and assurance and qualit (B) written quality assimprovement plan; (C) methods for mon quality and appropria including delineation utilization of services (D) professional or cl a requirement that st professionals and pro- shall be supervised be that area of service; (E) strategies for imp (F) review of staff qua- determination made treatment/habilitation (G) review of all fatal were being served in residential programs (H) adoption of stand and programmatic pe applicable standards purpose, "applicable means a level of com- reference to the prev- methods, and the de-	y improvement committee; surance and quality itoring and evaluating the ateness of client care, of client outcomes and ; inical supervision, including aff who are not qualified ovide direct client services by a qualified professional in proving client care; alifications and a to grant privileges: ities of active clients who area-operated or contracted at the time of death; lards that assure operational erformance meeting of practice. For this standards of practice"					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: MHL084-098						(X3) DATE SURVEY COMPLETED	
		B. WING	03	03/10/2022			
AME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE,	ZIP CODE			
IEW LON	DON GROUP HOME		IGHWAY 740 NDON, NC 28127				
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN C	F CORRECTION	(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN) THE APPROPRIATE	COMPLET	
V 105	Continued From page	e 2	V 105				
	This Rule is not met as evidenced by: Based on record review and interview, the facility failed to develop and implement adoption of standards that ensured operational and programmatic performance meeting applicable standards of practice for random drug testing instrument including the CLIA (Clinical Laboratory Improvement Amendments) waiver. The findings are:						
	-Admission date of 2/ -Diagnoses of Border Bipolar Disorder, Cur Moderate, Major Dey Unspecified, Mild Inte Disability, Type 2 Dia Complications and G Disease Without Eso -Physician order date following orders: -Blood Glucose three times a week. -BD Pen Needle with Levemir Flex per -Levemir Injection subcutaneously at be	Ine Personality Disorder, rent Episode Depressed, pressive Disorder, Recurrent ellectual Developmental betes Mellitus Without Gastro-Esophageal Reflux phagitis. ed 2/21/22 included the Test - Check Blood Glucose 31Gx 5mm - use as directed n. n - Inject 20 unit edtime. .5/0-5 - inject.5ml					
	Review on 3/10/22 of revealed: -There was no evider	f the facility's documents nce of a CLIA waiver.					
	Observation on 3/10/ medication revealed: -The injection was in refrigerator.						

STATE FORM

7NMY11

Division of Health Service Regulation STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL084-098		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		B. WING		0.4	03/10/2022		
			ADDRESS, CITY, STATE,		03/10/2022		
EW LON	DON GROUP HOME		IIGHWAY 740 DNDON, NC 28127				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE COMPLE THE APPROPRIATE DATE		
V 105	Continued From page 3		V 105				
	-Documentation of blood sugar check was recorded.						
	revealed: -Confirmed staff adm sugar checks and inj	with the Program Manager ninistered client #3's blood ections. ty did not have a CLIA					

7NMY11