	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED	
					R	
		MHL001-232	B. WING		08/15/20	
AME OF PF	OVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	ZIP CODE		
HANGIN	G LIVES FAMILY CARE	HOMELIC	RONS WAY			
		BURLIN	GTON, NC 27217			
(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 COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLE ⁻ DATE
V 000	INITIAL COMMENTS	3	V 000			
	completed on August	and complaint survey was 15, 2022. The complaint 0) was substantiated. There ed.				
	category: 10A NCAC	d for the following service 27G. 5600A Adults with Mental Illness				
	has a census of 5.	d for 5 beds and currently onsisted of audits of 3				
V 114	27G .0207 Emergend	cy Plans and Supplies	V 114			
	10A NCAC 27G .020 AND SUPPLIES (a) A written fire plan	7 EMERGENCY PLANS				
	area-wide disaster pl	an shall be developed and the appropriate local				
	and evacuation proce posted in the facility.	made available to all staff edures and routes shall be drills in a 24-hour facility				
	shall be held at least repeated for each sh under conditions that	quarterly and shall be ift. Drills shall be conducted simulate fire emergencies. have basic first aid supplies				
	failed to conduct fire	ew and interview the facility and disaster drills on each				
	shift at least quarterly	/. I ne findings are:				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			SURVEY
			A. BUILDING:		R 08/15/2022	
		MHL001-232	B. WING			
IAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
HANGIN	G LIVES FAMILY CARE		RONS WAY			
		BURLIN	GTON, NC 27217			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY 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 114	Continued From pag	e 1	V 114			
	disaster drills record -There were 2nd shift 2/1/22, 3/16/22, 4/11 7/12/22 and 8/4/22. -There was one 2nd 1/11/22. -There were no fire a on 1st and 3rd shift. Interview on 8/15/22 revealed: -Staff was aware fire conducted on each s -Clients would leave program. -He would have the v shift fire and disaster	It disaster drills conducted on /22, 5/23/22, 6/13/22, shift fire drill conducted on and disaster drills conducted with the Executive Director and disaster drills should be shift. early on 1st shift for the day weekend staff conduct 1st r drills on the weekends.				
V 118	 10A NCAC 27G .020 REQUIREMENTS (c) Medication admir (1) Prescription or no only be administered order of a person au drugs. (2) Medications shall clients only when au client's physician. (3) Medications, inclu 	9 MEDICATION	V 118			

Division of Health Service Regulation STATE FORM

6899

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED
			A. BUILDING:			
		MHL001-232	B. WING		08	R 8/ 15/2022
IAME OF PF	OVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	, ZIP CODE		
	G LIVES FAMILY CARE		ONS WAY			
		BURLING	GTON, NC 27217			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 118	Continued From pag	ge 2	V 118			
	 (4) A Medication Adr all drugs administered current. Medications recorded immediate MAR is to include th (A) client's name; (B) name, strength, (C) instructions for a (D) date and time th (E) name or initials of drug. (5) Client requests for checks shall be record 	e and administer medications. ministration Record (MAR) of ed to each client must be kept a administered shall be ly after administration. The e following: and quantity of the drug; administering the drug; e drug is administered; and of person administering the or medication changes or orded and kept with the MAR ppointment or consultation				
	interview, the facility medication on the w physician for one of are: Review on 8/11/22 of	on, record review and failed to administer ritten authorization of a three clients (#1). The finding of Client #1's record revealed:				
	Disorder, Mild, Canr Hallucinogen Use D Remission. -Physicians orders in	ophrenia, Tobacco Use nabis Use Disorder, Mild and isorder, In Sustained ncluded the following dates: f is to take blood pressure				
	every morning and r	ecord. Notify provider if blood is over 150 or less than 100."				

STATE FORM

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			
	MHL001-232 B. WIN		B. WING		08	R / 15/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE, 2	ZIP CODE		
HANGIN	G LIVES FAMILY CARE	HOME, LLC	RONS WAY			
		BURLIN	GTON, NC 27217			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 118	Continued From pag	e 3	V 118			
	-6/9/22 - "Staff to Blood Pressure daily -7/11/22 - "Prop Take one tablet (10m heart rate. Notify pro -7/28/22 Start P a.m. Monitor heart ra Notify provider for he systolic BP less than Review on 8/11/22 of Administration Recor revealed: -There was no evide pressure and heart ra -There was no record pressure and heart ra -He did respond whe pressure checks and Interview on 8/11/22 -He worked three da -Client #1 self-admin -The Nurse Practition electronic machine. -Client #1 was to che the a.m. -He told client #1 to of heart rate every mon -Client #1 did not wa -Client #1 was suppo pressure/heart rate u -He said client #1's m	o assist patient with taking ." ranolol HCL 10mg oral tablet ng) by mouth daily. Monitor vider if rate is less than 70." ropranolol 20mg take daily in ate and blood pressure daily. eart rate less than 70 and 100." f Client #1's Medication rd from April 2022 - July 2022 nce client #1's blood ate was checked. ding of client #1 revealed: nderstanding of blood ate check. en asked about blood I heart rate. with Staff #2 revealed: ys a week/24hr shift. istered blood pressure. her ordered client #1 an eck blood pressure daily in check blood pressure and ning. nt to do it.				

	of Health Service Regu FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
		MHL001-232	B. WING		R 08/15/2	
AME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
		207 AAR	RONS WAY			
ANGIN	G LIVES FAMILY CARE	BURLIN	GTON, NC 27217			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO	THE APPROPRIATE	COMPLET DATE
V 440				DEFICIEN	51)	
V 118			V 118			
		with Staff #3 revealed:				
	-He worked the week					
		1 had to self-administer the				
	blood pressure and h	t know how to use the				
	machine.					
	-He said he would need training.					
	Interview on 8/12/22	with the Registered Nurse				
	revealed:					
	-She was an indepen	ndent contractor.				
	-She worked on the weekends and sometimes					
	during the week.					
	-She provided nursing duties, assessed clients,					
	trainings, contribute to the treatment plan,					
	communicating with	providers and medication				
	administration.					
		sked if she reviewed clients				
	doctor orders.					
		the Qualified Professional				
		w clients records and doctor				
	orders.					
	Interview on 8/11/22					
	Qualified Professiona					
	-She was told client # self-administered.	#1's order was for him to				
	-Staff told her includi	ng weekend staff that client				
	#1 would do it sporad	dically.				
		client #1's room and by his				
	bed.					
	-She thought the orde	-				
	-She would ensure th	ne RN trained all staff.				
		with the Executive Director				
	revealed:					
		s responsible for reviewing				
		rent and new doctor orders				
	and MARS. -He would discuss wi	ith the PN her				
	alth Service Regulation					

STATE FORM

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		(X3) DATE COMP	SURVEY LETED
			A. BUILDING:			
		MHL001-232	B. WING		R 08/15/2	
ME OF PF	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE,	ZIP CODE		
HANGIN	G LIVES FAMILY CARE	HOMELLC	RONS WAY			
		BURLIN	GTON, NC 27217			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLET DATE
V 118	Continued From pag	e 5	V 118			
	responsibilities.					
V 291	27G .5603 Supervise	ed Living - Operations	V 291			
	10A NCAC 27G .560	3 OPERATIONS				
	(a) Capacity. A facility shall serve no more than					
	six clients when the clients have mental illness or developmental disabilities. Any facility licensed					
	on June 15, 2001, and providing services to more					
	than six clients at that time, may continue to					
	provide services at no more than the facility's					
	licensed capacity. (b) Service Coordination. Coordination shall be					
	. ,	the facility operator and the				
		Is who are responsible for				
		n or case management.				
	(c) Participation of the					
	-	Each client shall be nity to maintain an ongoing				
		or his family through such				
	-	e facility and visits outside				
		shall be submitted at least				
		nt of a minor resident, or the				
		erson of an adult resident. riting or take the form of a				
	conference and shall	•				
		eting individual goals.				
	., -	es. Each client shall have				
		based on her/his choices,				
	needs and the treatm	•				
		signed to foster community nay be limited when the court				
		volved or when health or				
	safety issues becom					
	This Rule is not met	as evidenced by:				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		MHL001-232	 B. WING		08	R / 15/2022
	ROVIDER OR SUPPLIER	l.	DDRESS, CITY, STATE		00	10/2022
		207 AAR				
HANGIN	G LIVES FAMILY CARE I	HOME, LLC	GTON, NC 27217			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE) THE APPROPRIATE	(X5) COMPLET DATE
V 291	Continued From page	e 6	V 291			
	failed to coordinate medical services with other professionals responsible for treatment/habilitation of client (#1). The findings are:					
	-Admission date of 12 -Diagnoses of Schizo Disorder, Mild, Canna Hallucinogen Use Dis Remission. -Physicians orders ind -4.14.22 - "Staff i every morning and re pressure is systolic is -6/9/22 - "Staff to Blood Pressure daily. -7/11/22 - "Propra Take one tablet (10m heart rate. Notify prov -7/28/22 Start Pro a.m. Monitor heart rate	abis Use Disorder, Mild and sorder, In Sustained cluded the following dates: is to take blood pressure cord. Notify provider if blood over 150 or less than 100." assist patient with taking " anolol HCL 10mg oral tablet g) by mouth daily. Monitor <i>v</i> ider if rate is less than 70." opranolol 20mg take daily in te and blood pressure daily. art rate less than 70 and				
	-Presented limited un pressure and heart ra -He did respond when pressure checks and	ate check. n asked about blood heart rate.				
	-He worked three day -Client #1 self-admini check. -The Nurse Practition electronic machine.	stered blood pressure er ordered client #1 an				
sion of Use	the a.m.	ck blood pressure daily in heck blood pressure and				

STATE FORM

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED
	FCORRECTION	IDENTIFICATION NOWBER.	A. BUILDING:			FLETED
		MHL001-232	B. WING		08	R 8/ 15/2022
AME OF PF	ROVIDER OR SUPPLIER	STREETA	DDRESS, CITY, STATE	, ZIP CODE		
	G LIVES FAMILY CARE		RONS WAY			
	S EIVESTAMIET CARE	BURLIN	GTON, NC 27217			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEI	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLET DATE
V 291	Continued From page	e 7	V 291		,	
	heart rate every morr					
	-Client #1 did not wai					
	-Client #1 was supposed to check blood pressure/heart rate until the NP discontinued it.					
	Interview on 8/12/22	with Staff #3 revealed:				
	-He worked on the weekends.					
	-He was told client #1 had to self-administer the					
	blood pressure and heart rate.					
	-Confirmed he did no	t know how to use the				
	machine.					
	-He said he would need training.					
	-The Registered Nurse would check client #1's					
	blood pressure and heart rate if she came on the					
	weekends.					
	Interview on 8/12/22 revealed:	with the Registered Nurse				
	-She was an indepen	ident contractor				
		weekends and sometimes				
	during the week.					
		g duties, assessed clients,				
	trainings, contribute t					
		providers and medication				
	administration.					
	-She denied when as	sked if she reviewed clients				
	doctor orders.					
	-She reported it was	the Qualified Professional				
	responsibility to revie	w clients records and doctor				
	orders.					
	-She would train staff	f to check and monitor client				
	•	and heart rate with the				
	machine.					
	Interview on 8/12/22	with the Nurse Practitioner				
	revealed:					
	-She provided primar	y care services about every				
	3-6 weeks.					
		client #1's blood pressure				
	and heart rate was ex	vtromoly high				1

	F OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		(X3) DATE COMP	SURVEY LETED
			A. BUILDING:			
		MHL001-232	B. WING		R 08/15/	
IAME OF PI	ROVIDER OR SUPPLIER	STREET	DDRESS, CITY, STATE	ZIP CODE		
HANGIN	G LIVES FAMILY CARE	HOME. LLC	RONS WAY			
		BURLIN	GTON, NC 27217			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLET DATE
V 291	Continued From pag	le 8	V 291			
	-She left a blood pre	ssure cuff that would monitor				
	pressure and heart r					
		ked for the company refused				
	to take blood pressu weekends.					
		self-administer order				
	-She did not write a self-administer order. -She did not discontinue the order.					
	-Client #1had on and off had blood pressure					
	issues.					
		monitoring blood pressure				
	-	ps to where it download to a				
		left one for alignt #1				
	-On the 4/14/22 she left one for client #1.					
	-Staff was to take blood pressure every morning					
	and record. -Order also indicated to notify provider if blood					
		c over 150 or less than 100.				
	-Pulse had been ove					
		lication caused an increased.				
		ff about the blood pressure				
	checks.					
	Interview on 8/11/22	and 8/15/22 with the				
	Qualified Profession	al revealed:				
	-She was told client	#1's order was for him to				
	self-administered.					
	-She thought the ord	ler was discharged.				
		he Nurse Practitioner for a				
	new order.					
		responsible for reviewing				
		urrent and new doctor orders.				
		he RN trained all staff to use				
	the heart rate and bl	ood pressure machine.				
		with the Executive Director				
	revealed:	e reeneneible for reviewing				
		s responsible for reviewing				
		Irrent and new doctor orders.				
	-He would discuss w					
	responsibilities.					

STATE FORM

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLI AND PLAN OF CORRECTION IDENTIFICATION NU			(X2) MULTIPLE CO	(X3) DATE SURVEY COMPLETED		
		DERTH TO/TTOIT TO/TTOIT TO/TTOIT	A. BUILDING:			
		MHL001-232	B. WING		08	R / 15/2022
AME OF PR	OVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	ZIP CODE		
HANGING		E HOME, LLC	RONS WAY			
		BURLIN	IGTON, NC 27217			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEI	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLET DATE