Division of Health Service Regulation

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
74121 2741	or contraction	IDENTIFICATION NO.	A. BUILDING:			
		MHL078-150	B. WING		R 06/07/2022	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STAT	E, ZIP CODE		
норе но	USE		LOWERY ROAD N, NC 28386			
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
V 000	INITIAL COMMENTS		V 000			
	on June 7, 2022. Defi This facility is licensed 10A NCAC 27G .1700 Staff Secure for Child This facility is licensed	d for the following category: O Residential Treatment				
V 114	AND SUPPLIES  (a) A written fire plan area-wide disaster plashall be approved by authority.  (b) The plan shall be and evacuation proceposted in the facility.  (c) Fire and disaster coshall be held at least repeated for each shi under conditions that	7 EMERGENCY PLANS for each facility and an shall be developed and	V 114			
	failed to have fire and quarterly and repeate are:	as evidenced by: ew and interview the facility I disaster drills held at least d on each shift. The findings of facility records from June				
	olth Service Pegulation	•	1		l .	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING:		(X3) DATE COMI	SURVEY PLETED	
		MHL078-150	B. WING		06	R / <b>07/2022</b>
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE		
норе но	USE		D LOWERY ROAD ON, NC 28386			
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO		(X5) COMPLETE
TAG	,	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO TH DEFICIENCY	E APPROPRIATE	DATE
V 114	Continued From pag	ge 1	V 114			
	2021-June 2022 rev	ealed:				
	- No documented fire	e or disaster drills for the 1st				
	quarter of 2022.					
	_	and disaster drill was				
		2nd quarter of 2022.				
	- Only one disaster of documented for the					
		or disaster drills for the 4th				
	quarter for 2021.	of disaster diffis for the 4th				
	During interview on	06/03/22 the Program				
	Director revealed:					
		essional was new was				
	continuing to learn h	•				
	were completed and	he fire and disaster drills documented.				
	This deficiency cons and must be correct	titutes a re-cited deficiency ed within 30 days.				
V 118	27G .0209 (C) Medi	cation Requirements	V 118			
	10A NCAC 27G .020 REQUIREMENTS	09 MEDICATION				
	(c) Medication admir	nistration:				
	` '	on-prescription drugs shall				
	. ,	d to a client on the written				
	1	thorized by law to prescribe				
	drugs.					
		I be self-administered by				
		thorized in writing by the				
	client's physician.					
		uding injections, shall be				
	,	/ licensed persons, or by				
		trained by a registered nurse, legally qualified person and				
		e and administer medications.				
		ministration Record (MAR) of				
		ed to each client must be kept				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 1	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL078-150	B. WING	B. WING		R 5 <b>/07/2022</b>
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STAT	E, ZIP CODE		
НОРЕ НО	USE		D LOWERY ROAD	)		
	Г		ON, NC 28386			
(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 C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
V 118	current. Medications a recorded immediately MAR is to include the (A) client's name; (B) name, strength, at (C) instructions for ad (D) date and time the (E) name or initials of drug.  (5) Client requests for checks shall be recorded.	administered shall be r after administration. The following: nd quantity of the drug;	V 118			
	affecting one of three the MARs current affe and #3) and 2 of 5 star medication administration person (Associate Pro #8). The findings are Finding #1: Review on 06/03/22 or revealed: -17 year old maleAdmission date of 04	ews, observation and failed to administer ritten order of a physician clients (#2), failed to keep ecting 3 of 3 clients (#1, #2 aff were not trained in ation by a legally qualified ofessional (AP) and staff:  of client #2's record				
	A. Review on 06/03/2	2 of client #2's physician's				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _		_
		MHL078-150	B. WING		R <b>06/07/2022</b>
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
НОРЕ НО	IICE	3775 OLD	LOWERY ROA	D	
HOPE HO		SHANNOI	N, NC 28386		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
V 118	Continued From page	2 3	V 118		
	orders revealed: 04/29/22 -Guanfacine 2mg (mil Take 1 by mouth ever-Aripiprazole 5mg (Tr tablet by mouth in mo-Trazodone 50mg (Tr by mouth at bedtime. 06/02/22 -Vyvanse 60mg (Treatevery morning.  Review on 06/03/22 of 2022 MARs revealed transcribed entries: -Guanfacine 2mg-04/04/07/22-04/08/22, 08-Aripiprazole 5mg-04/04/07/22-04/08/22, 08-Aripiprazole 5mg-04/04/07/22-04/08/22, 08-17-azodone 60mg-04/07/22-05/03/22, 08-17-azodone 60mg-04/07/05/01/22-05/03/22, 08-17-azodone 60mg-04/07/22-05/03/22, 08-17-azodone 60mg-04/07/2	ligrams) (Treats ADHD) by morning. eats Schizophrenia) Take 1 rrning. eats Insomnia) Take 1 tablet  Its ADHD) Take 1 by mouth  of client #1's April and May the following blanks and  01/22-04/05/22, 1/16/22-04/17/22, 1/06/22, 05/25/22. 1/122-04/05/22, 1/22-04/05			

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04/04/22.

-He was 17 and was admitted to the facility on

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			7 t. Boilebiito.		R	
		MHL078-150	B. WING	B. WING		7/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
HOPE HOUSE 3775 OLD			LOWERY ROA	D		
		SHANNON	I, NC 28386			
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
V 118	Continued From page	e 4	V 118			
V 1110	-He received therapy prescribed medication -He was able to recal medicationsHe had missed his V daysHe was told there was Vyvanse from the pharacteristic -Vyvanse was the medication was out of his Vyvanse -He wrote in the community was out of his Vyvanse -He also contacted Simedication was out.  During interview on O Professional revealed -She started working April 2022Staff #7 told her on V client #2 was out of V During interview on O Director revealed: -She had been having medication from the paramacy staffShe was in the proceedients to a new medication story and started working apharmacy staffShe was also going the started working was also going the started to receive the proceedients to a new medication from the proceedients to a new medication started was also going the sta	at the facility and had been as by a doctor.  I all of his prescribed  Yyvanse for the past three as a problem with getting the armacy. Edication "he needed most."  6/03/22 staff #7 revealed: dications in the evening. munication log that client #2 se. taff #9 and informed her the  6/03/22 the Associate d: at the facility at the end of  Wednesday (06/01/22) that fyvanse.  6/03/22 the Program  g a hard time getting the obarmacy. obarmacy about client #2's and was not able to speak to  ess of transferring all of the cal clinic. to change pharmacies to be ation and to prevent the	V 110			
	Finding #2:	of aliant #1'a racerd				

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revealed:

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Division c	<u>of Health Service Regu</u>	ılation			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
					R
		MHL078-150	B. WING		06/07/2022
					1 00:0::=0==
NAME OF PR	ROVIDER OR SUPPLIER		DDRESS, CITY, STA	•	
HOPE HO	USE		D LOWERY ROA	D	
			ON, NC 28386		
(X4) ID		TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	()
PREFIX TAG	,	LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPE	
				DEFICIENCY)	
V 118	Continued From page		V 118		
	-14 year old male.	0/00/04			
	-Admission date of 06			ĺ	
		raumatic Stress Disorder,		İ	
	Disorder.	d Oppositional Defiant			
	Disorder.				
	Review on 06/03/22 (	of client #1's physician's			
	orders revealed:	, enem :			
	02/21/22				
	-Divalproex SOD DR	25mg (Treats Manic			
	Depression) Take 1 to	ablet by mouth in the			
	morning.			ĺ	
	-Guanfacine 4mg (Tre				
	••	er (ADHD) Take 1 tablet at			
	bedtime	Aid\ Taka 4 tablat by			
	- ,	ep Aid) Take 1 tablet by		İ	
	mouth in the morning 05/18/22	I•			
		mg (Treats ADHD) Take 1			
	tablet by mouth daily.				
	Review on 06/03/22 of	of client #1's April and May			
	2022 MARs revealed	the following blanks and			
	transcribed entries:				
		25mg-05/1/22-05/03/22.			
	_	/27/22-04/28/22, 05/05/22,			
	05/28/22.	7/22 24/22/22 25/25/20			
	_	7/22-04/28/22, 05/05/22,			
	05/28/22.	mg-05/01/22-05/03/22,			
	05/15/22.	119-05/01/22-05/05/22,			
	00/10/22.				
	Interview on 06/03/22	2 client #1 stated:			
		to the group home from a		ĺ	
	sister facility in 2021.	<b>.</b>			
	-His doctor prescribe	d medications for him.			
	-He received his med	lications daily as ordered.			
	Finding #3:				

Review on 06/03/22 of client #3's record

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Division of	of Health Service Regu	liation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMP	PLETED
						R
		MHL078-150	B. WING	B. WING		/07/2022
		11112070-100	I		1 00	0112022
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	ΓE, ZIP CODE		
HOPE HO	IISE	3775 OLI	LOWERY ROA	D		
1101 = 110	00L	SHANNO	N, NC 28386			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORE	RECTION	(X5)
PREFIX	•	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF		COMPLETE DATE
TAG	REGULATORT OR I	LGC IDENTIFTING INFORMATION)	TAG	DEFICIENCY)	PROPRIATE	BATE
V 118	Continued From page	e 6	V 118			
	revealed:					
	-14 year old male.					
	-Admission date of 11	1/13/20				
		raumatic Stress Disorder,				
	•	Disorder, Unspecified				
		Attention Deficit Hyperactivity				
	•	ve Mood Dysregulation				
	Disorder.	, ,				
	Review on 06/03/22 of	of client #3's physician				
	orders dated 08/05/2	1 revealed:				
	-Clonidine 0.1mg (for	sleep) - take one daily.				
	, .	ar Disorder) 300mg and -				
	take twice daily.					
	-Lithium 150mg - take					
		chotic) 1mg - take 1/2 tablet				
	in morning and 1 table					
	•	ADHD) 2mg - take one tablet				
	every morning.					
	• •	nal allergies) 5mg take once				
	daily.					
	Davious on 06/02/22	of client #2's April and May				
		of client #3's April and May the following blanks and				
	transcribed entries:	The following blanks and				
		or 7 days) - 5/28/22 and				
	05/29/22.	or 7 days) - 3/20/22 and				
	-Lithium 300mg - 05/0	01/22 thru 05/03/22				
	05/06/22 and 05/28/2	•				
	-Lithium 150mg - 05/2					
	•	22 thru 05/03/22, 05/06/22				
	and 05/28/22.	,				
		22 thru 05/03/22, 05/06/22				
	and 05/28/22.	•				
	-Zyrtec - 05/01/22 thr	u 05/03/22, 05/06/22 and				
	05/28/22.	•				
	Interview on 06/03/22	2 client #3 stated:				
	-He had lived at the g	group home since 11/2020.				

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-He saw a doctor for his medications.

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND FLAN	OF CORRECTION	IDENTIFICATION NOMBER.	A. BUILDING: _		COMPLETED
		MHL078-150	B. WING		R 06/07/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
норе но	USF	3775 OLD	LOWERY ROA	D	
		SHANNO	N, NC 28386		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
V 118	Continued From page	e 7	V 118		
	-He knew all of his me administered at the fa	edications that were			
	-Hire date of 04/27/22	of the AP's record revealed: 2. f medication administration			
	Review on 06/03/22 of staff #8's record revealed: -Hire date of 05/16/22No documentation of medication administration training.				
		s/22 while in the facility at am revealed the AP and staff e facility upon arrival.			
	-She did administer m -She worked 12 hour -She would administe "at times." -The morning medica				
	administration training	did not have medication g. rking at the facility after she			
	Due to the failure to a medication administra determined if client # medication as ordered	ation it could not be 1 and client #3 received their			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION		(X3) DATE SURVEY	
OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMP	LETED	
					R	
	MHL078-150	B. WING	B. WING		07/2022	
ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE			
	3775 OLD	LOWERY ROA	D			
USE	SHANNO	N, NC 28386				
SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)	
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO	TION SHOULD BE THE APPROPRIATE	COMPLETE DATE	
Continued From page	e 8	V 118				
dated 06/03/22 and of Director revealed: "-What immediate active ensure he safety of the Require the manager ensure all members happens. AP will be responded because they can not timely mannerDescribe your plans happens. I will be condaily and [pharmacy endowed the condaily endowed the condai	tion will the facility take to ne consumers in your care? In check MAR & meds daily to nave meds. With control consible for informing cy of refills. We are in the medication providers it seem to met our needs in a to make sure the above staff] weekly to ensure all					
which included Condi Stress Disorder, Opp Reactive Attachment Sexual Dysfunction, A Disorder and Disrupti Disorder. In the mon 2022 client #2 was no Vyvanse 60mg becaumedication on 04/23/ 05/30/22-6/3/22. Clie multiple blanks on the Staff #8 and the AP w 06/03/22 and neither Medication Administrationstitutes a Type B detrimental to the heat the clients. If the viol 45 days, an administrations	uct Disorder, Post Traumatic ositional Defiant Disorder, Disorder, Unspecified Attention Deficit Hyperactivity ive Mood Dysregulation ths of April, May and June of able to receive his use the facility ran out of 22-04/29/22 and ents #1, #2 and #3 had ents #1, #2 and #3 had expril and May 2022 MARs. worked at the facility on staff had been trained in ation. This deficiency rule violation which is alth, safety and welfare of ation is not corrected within rative penalty of \$200.00 per					
	ROVIDER OR SUPPLIER  SUMMARY ST (EACH DEFICIENC) REGULATORY OR  Continued From page  Review on 06/03/22 of dated 06/03/22 and of Director revealed: "-What immediate accensure he safety of the Require the manager ensure all members he meds, AP will be residirector, and pharmal process of changing because they can not timely mannerDescribe your plans happens. I will be conditive and [pharmacy medication requiremed]  Clients ranged in age which included Cond Stress Disorder, Opp Reactive Attachment Sexual Dysfunction, and Disorder and Disruption Disorder. In the mond 2022 client #2 was not all the sexual Dysfunction on 04/23/05/30/22-6/3/22. Client with the sexual Dysfunction on 04/23/05/30/22 and neither Medication Administration constitutes a Type B detrimental to the heat the clients. If the viol 45 days, an administration will be imposed for the summary of the clients. If the viol 45 days, an administration will be imposed for the summary of the clients. If the viol 45 days, an administration will be imposed for the summary of the clients. If the viol 45 days, an administration will be imposed for the clients. If the viol 45 days, an administration will be imposed for the clients.	MHL078-150  ROVIDER OR SUPPLIER  STREET AD  3775 OLE  SHANNO  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 8  Review on 06/03/22 of the Plan of Protection dated 06/03/22 and completed by the Program Director revealed: "-What immediate action will the facility take to ensure he safety of the consumers in your care? Require the manager check MAR & meds daily to ensure all members have meds. With control meds, AP will be responsible for informing director, and pharmacy of refills. We are in the process of changing medication providers because they can not seem to met our needs in a	MHL078-150  MHL078-150  STREET ADDRESS, CITY, STA 3775 OLD LOWERY ROAI SHANNON, NC 28386  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 8  V 118  Review on 06/03/22 of the Plan of Protection dated 06/03/22 and completed by the Program Director revealed: "-What immediate action will the facility take to ensure he safety of the consumers in your care? Require the manager check MAR & meds daily to ensure all members have meds. With control meds, AP will be responsible for informing director, and pharmacy of refills. We are in the process of changing medication providers because they can not seem to met our needs in a timely mannerDescribe your plans to make sure the above happens. I will be collaborating with the manager daily and [pharmacy staff] weekly to ensure all medication requirements are being met."  Clients ranged in ages from 14-17 with diagnoses which included Conduct Disorder, Post Traumatic Stress Disorder, Oppositional Defiant Disorder, Reactive Attachment Disorder, Unspecified Sexual Dysfunction, Attention Deficit Hyperactivity Disorder and Disruptive Mood Dysregulation Disorder. In the months of April, May and June 2022 client #2 was not able to receive his Vyvanse 60mg because the facility ran out of medication on 04/23/22-04/29/22 and 05/30/22-6/3/22. Clients #1, #2 and #3 had multiple blanks on the April and May 2022 MARs. Staff #8 and the AP worked at the facility on 06/03/22 and neither staff had been trained in Medication Administrative penalty of \$200.00 per day will be imposed for each day the facility is out	ROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  3775 OLD LOWERY ROAD SHANNON, NC 28386  SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 8  V 118  Review on 06/03/22 of the Plan of Protection dated 06/03/22 and completed by the Program Director revealed: "What immediate action will the facility take to ensure he safety of the consumers in your care? Require the manager check MAR & meds daily to ensure all members have meds. With control meds, AP will be responsible for informing director, and pharmacy of refills. We are in the process of changing medication providers because they can not seem to met our needs in a timely manner.  Describe your plans to make sure the above happens. I will be collaborating with the manager daily and (pharmacy staff) weekly to ensure all medication requirements are being met."  Clients ranged in ages from 14-17 with diagnoses which included Conduct Disorder, Post Traumatic Stress Disorder, Oppositional Defiant Disorder, Reactive Attachment Disorder, Unspecified Sexual Dysfunction, Attention Deficit Hyperactivity Disorder and Disruptive Mood Dysregulation Disorder. In the months of April, May and June 2022 client #2 was not able to receive his Vyvanse 60mg because the facility ran out of medication on 04/23/22-04/29/22 and 05/30/22-63/322. Clients #1, #2 and #3 had multiple blanks on the April and May 2022 MARs. Staff #8 and the AP worked at the facility in on 06/03/03/22 and neither staff had been trained in Medication Administration. This deficiency constitutes a Type B rule violation which is detrimental to the health, safety and welfare of the clients. If the violation is not corrected within 45 days, an administrative penalty of \$200.00 per day will be imposed for each day the facility is out	MHL078-150  BYANG  BYAN	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
					R
		MHL078-150	B. WING		06/07/2022
			1		1 00/01/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
HOPE HOUSE			LOWERY ROA	D	
		SHANNON	I, NC 28386		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
V 121	governing body or op for obtaining a review regimen at least ever shall be to be perforn physician. The on-site the client's physician the review when med	es psychotropic drugs, the erator shall be responsible of each client's drug y six months. The review ned by a pharmacist or e manager shall assure that is informed of the results of lical intervention is indicated. e drug regimen review shall ent record along with	V 121		
	facility failed to obtain of 3 clients (#1, #2, a psychotropic medicat Review on 06/03/22 orevealed: -14 year old maleAdmission date of 06-Diagnoses of Post T Conduct Disorder and Disorder Signed and dated p psychotropic medicat 02/21/22	ews and interviews the a drug regimen reviews for 3 and #3) who received dions. The findings are:  of client #1's record  6/29/21.  raumatic Stress Disorder, doppositional Defiant  thysician's orders for dions as follows:  25mg Take 1 tablet by			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BOILBING.			
		MHL078-150	B. WING	B. WING		7/2022
NAME OF PR	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
HOPE HO	JSE		LOWERY ROA	D		
			N, NC 28386			
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
V 121	Continued From page	e 10	V 121			
	05/18/22 -Methylphenidate 50r daily No documented dru	ng Take 1 tablet by mouth g regimen reviews.				
	Reactive Attachment Sexual Dysfunction, A Disorder and Disrupti Disorder Signed and dated pl psychotropic medicat 02/07/22 -Lithium Carbonate 1 bedtimeClonidine 0.1mg Tak -Lithium Carbonate 3 7am and 7pmRisperidone 1mg Tal (morning) and 1 table	raumatic Stress Disorder, Disorder, Unspecified Attention Deficit Hyperactivity ve Mood Dysregulation hysician's orders for ions as follows:  50mg Take 1 by mouth at e 1 by mouth at bedtime. 00mg Take 1 by mouth at ixe 1/2 tablet by mouth in am et by mouth at night. ixe 1 tablet by mouth in the				
	Director revealed: -She had not had dru completed.	-				
V 123	27G .0209 (H) Medica 10A NCAC 27G .0209 REQUIREMENTS	·	V 123			
		Drug administration errors				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 1	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			
			A. BOILDING.			R
		MHL078-150	B. WING		06	6/07/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	E, ZIP CODE		
НОРЕ НО	IIEE	3775 OLI	D LOWERY ROAD			
HOPE HO	U3E	SHANNO	ON, NC 28386			
(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 TI DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
V 123	Continued From page	e 11	V 123			
	reported immediately pharmacist. An entry and the drug reaction	se drug reactions shall be to a physician or of the drug administered shall be properly recorded client's refusal of a drug				
	This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to notify the physician or pharmacist immediately of medication errors affecting one of three clients (#2). The findings are:  Refer to V118 regarding medication requirements.					
	Review on 06/03/22 of revealed: -17 year old maleAdmission date of 04 -Diagnoses of Attention Disorder and Conduction	1/04/22. on Deficit Hyperactivity				
	Medication Administra - Client #1 was not ac from 04/23/22-04/29/3 - No documentation the	of client #2's April-June 2022 ation Records revealed: dministered Vyvanse 60mg 22 and 05/30/22-06/03/22. he physician or pharmacist tely of the medication error				
	Professional revealed	6/03/22 the Associate d: in the staff communication				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			7. Bolesino.		R	
MHL078-150		B. WING		06/07/2022		
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
норе но	IISE	3775 OLD I	OWERY ROA	D		
		SHANNON	NC 28386			
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
V 123	Continued From page	2 12	V 123			
	log the Vyvanse for client #2 had been out since 05/30/22Client #2's Vyvanse still had not been filled.  Interview on 06/03/22 the Program Director revealed: -She had not contacted the physician or pharmacist because she did not know client #2 did not have the medication.					
V 364	G.S. 122C- 62 Additi Facilities	onal Rights in 24 Hour	V 364			
	122C-51 through G.S who is receiving treat 24-hour facility keeps (1) Send and receive access to writing mate assistance when need (2) Contact and consand at no cost to the physicians, and prival developmental disability professionals of his constant and constant and constant access to writing materials. Contact and constant access a client advoct The rights specified in restricted by the facility exercise these rights (b) Except as provided of this section, each attreatment or habilitation times keeps the right (1) Make and receive calls. All long distance access to writing the section of the secti	rights enumerated in G.S.  122C-61, each adult client ment or habilitation in a the right to: e sealed mail and have erial, postage, and staff essary; sult with, at his own expense facility, legal counsel, private te mental health, lities, or substance abuse hoice; and sult with a client advocate if eate. In this subsection may not be ty and each adult client may at all reasonable times. ed in subsections (e) and (h) adult client who is receiving on in a 24-hour facility at all				

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Division of Health Service Regulation						
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
	MILL 070 450		B. WING		R	
		MHL078-150	D. WIIVO		06/07/2022	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
		3775 OI	D LOWERY ROA	n		
HOPE HO	USE		ON, NC 28386			
			711, 110 20300	T		
(X4) ID			ID	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD	( - /	
PREFIX TAG			PREFIX TAG	CROSS-REFERENCED TO THE APPROP		
	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			DEFICIENCY)		
V 364	Continued From page	e 13	V 364			
	collect to the receivin	g party:				
		between the hours of 8:00				
	` '	r a period of at least six				
		s of which shall be after 6:00				
		g shall not take precedence				
	over therapies;	3 Shall flot take precedence				
	•	nd meet under appropriate				
	` '	riduals of his own choice				
	•					
	upon the consent of t					
	` '	de the custody of the facility				
	unless:					
	-	ceedings were initiated as				
		t's being charged with a				
		ng a crime involving an				
	assault with a deadly					
	-	d not guilty by reason of				
	insanity or incapable					
		oluntarily admitted or				
		lity while under order of				
	commitment to a corr					
		ection of the Department of				
	Public Safety; or					
		ng held to determine capacity				
	to proceed pursuant t					
	, ,	pressly authorize visits				
		by the existence of the				
	conditions prescribed	•				
	` '	daily and have access to				
		ent for physical exercise				
	several times a week					
		ited by law, keep and use				
		I possessions, unless the				
	•	determine capacity to				
	proceed pursuant to					
	(7) Participate in reli					
	(8) Keep and spend	a reasonable sum of his				
	own money;					
	(9) Retain a driver's	license, unless otherwise				
	prohibited by Chapter	r 20 of the General Statutes;				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _		35	
	MHL078-150		B. WING		R <b>06/07/2022</b>	
NAME OF P	ROVIDER OR SUPPLIER	STREET AF	DDRESS, CITY, STA	TE ZIP CODE		
NAME OF T	TOVIDER OR GOLT EIER		LOWERY ROA			
HOPE HO	USE		N, NC 28386			
(V4) ID	SLIMMARY ST.		·	PROVIDER'S PLAN OF CORRECTION	N (VE)	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
V 364	Continued From page	e 14	V 364			
	and					
		ndividual storage space for				
	his private use.	3 1				
	(c) In addition to the	rights enumerated in G.S.				
	122C-51 through G.S					
		5. 122C-61, each minor client				
	•	ment or habilitation in a				
	•	e right to have access to				
	proper adult supervision of the min	nor's status as a developing				
	individual, the minor s					
		le him to mature physically,				
	emotionally, intellectually, socially, and					
	vocationally. In view of the physical, emotional,					
		turity of the minor, the				
	24-hour facility shall p					
		and control consistent with				
		e minor pursuant to this Part.				
	•	, where practical, make ensure that each minor				
		ent apart and separate from				
		ne treatment needs of the				
	minor client dictate of					
	Each minor client who	o is receiving treatment or				
	habilitation from a 24-	-hour facility has the right to:				
		nd consult with his parents or				
	-	cy or individual having legal				
	custody of him;	and anish at his arm are are				
		sult with, at his own expense esponsible person and at no				
	cost to the facility, leg					
		ental health, developmental				
		nce abuse professionals, of				
		onsible person's choice; and				
		sult with a client advocate, if				
	there is a client advoc					
		n this subsection may not be				
	_	ty and each minor client				
	may exercise these ri	ghts at all reasonable times.				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
				R	
	MHL078-150	B. WING		06/07/2022	
NAME OF PROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
HOPE HOUSE		LOWERY ROA	D		
		I, NC 28386		Т	
PREFIX (EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE	
V 364 Continued From page	e 15	V 364			
(d) Except as provided of this section, each of treatment or habilitation the right to:  (1) Make and received distance calls shall be time of making the careceiving party;  (2) Send and received writing materials, possible when necessary;  (3) Under appropriation visitors between the form. for a period of at hours of which shall be the visiting shall not take therapies;  (4) Receive special distraining in accordance (5) Be out of doors of recreation, and physic basis in accordance (6) Except as prohib personal clothing and appropriate supervision held to determine cape (3.S. 15A-1002;  (7) Participate in reliful (8) Have access to in the safekeeping of personal clothing and appropriate supervision held to determine cape (9). Have access to in the safekeeping of personal clothing and appropriate in reliful (8) Have access to in the safekeeping of personal clothing and appropriate in reliful (8). Have access to in the safekeeping of personal clothing and the safekeep	ed in subsections (e) and (h) minor client who is receiving on in a 24-hour facility has e telephone calls. All long e paid for by the client at the all or made collect to the e mail and have access to tage, and staff assistance the supervision, receive mours of 8:00 a.m. and 9:00 at least six hours daily, two be after 6:00 p.m.; however precedence over school or education and vocational e with federal and State law; daily and participate in play, cal exercise on a regular with his needs; itted by law, keep and use a possessions under on, unless the client is being practicity to proceed pursuant to gious worship; and spend a reasonable sum	V 364			

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DIVISION	of Health Service Regu	lation				
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SU	IRVEY
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:			COMPLETED	
			7 50.125 (6			
					R	
		MHL078-150	B. WING		06/07	//2022
			•			
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE		
норе но	HEE	3775 OLD	LOWERY ROA	D		
HOPE HO	USE	SHANNO	N, NC 28386			
(V4) ID	SLIMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE	RIATE	DATE
				DEFICIENCY)		
V 204	0 " 15	40	1/ 204			
V 364	Continued From page	2 16	V 364			
	client's record that inc	dicates the detailed reason				
	for the restriction. The	e restriction shall be				
		ed to the client's treatment or				
		restriction is effective for a				
		30 days. An evaluation of				
	each restriction shall					
		at least every seven days,				
	I	riction may be removed.				
	Each evaluation of a	-				
		ent's record. Restrictions on				
	rights may be renewe					
		the qualified professional in				
		t states the reason for the				
		tion. In the case of an adult				
		en adjudicated incompetent,				
		n initial restriction or renewal				
	_	ts, an individual designated				
	_ ·	on the consent of the client,				
	be notified of the rest	riction and of the reason for				
	it. In the case of a mir	nor client or an incompetent				
		y responsible person shall				
	be notified of each ins	stance of an initial restriction				
	or renewal of a restric	ction of rights and of the				
	reason for it. Notificat	ion of the designated				
	individual or legally re	esponsible person shall be				
	documented in writing	g in the client's record.				
	`					
	This Rule is not met	as evidenced by:				
		ews and interviews, the				
		•				
	facility restricted the r	~				
		b) by restricting their ability to				
		ephone calls. The findings				
	are:					
	Review on 06/03/22 of	of client #1's record				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	(X2) MULTIPLE CONSTRUCTION		
			A. BUILDING:		R	
	MHL078-150		B. WING	B. WING		
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE		
норе но	USE		LOWERY ROA	D		
			N, NC 28386		1	
(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 CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
V 364	Continued From page	e 17	V 364			
V 364	SHANNON,  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL		V 364			
		ninutes to use the phone.  the people listed on the  the Licensee stated:				

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- She had not placed the client call schedule on

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			71. 501251110.		R	
		MHL078-150	B. WING		06/07/2022	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
HOPE HO	USE		OWERY ROA	D		
0/0.15	SHIMMADV ST.	SHANNON,	1	PROVIDER'S PLAN OF CORRECTION	d over	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
V 364	Continued From page	<del>:</del> 18	V 364			
	the consent page for clients at admission.  - She had started the process of including the information on the admission packet but her computer was stolen.  This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.					
V 736	27G .0303(c) Facility	and Grounds Maintenance	V 736			
	10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS (c) Each facility and its grounds shall be maintained in a safe, clean, attractive and orderly manner and shall be kept free from offensive odor.					
	was not maintained ir and orderly manner.	n and interview the facility n a safe, clean, attractive The findings are:				
	the facility.  -The eyes of the stove burnt substance.  -The walls in the living at the entrance into the couch.  -The wood floor in the	m revealed: were discolored throughout e were dirty with a black g room area were damage he kitchen and behind the e hallway was loose at				
		s. nallway had approximately 3 patched and not painted.				

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		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED		
		MHL078-150	B. WING		R <b>06/07/2022</b>		
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE			
НОРЕ НО	IICE	3775 OLD	LOWERY ROA	D			
HOPE HO		SHANNON	, NC 28386				
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLET	E	
V 736	Continued From page	e 19	V 736				
V 736	-A light bulb in the hal- No threshold from th -The empty bedroom to the bed and other a and the ceiling fan bla and dirtBedroom at the end the closet door on the peeling from the door bottom drawerClient #1's bedroom The dresser drawers center. The paint was next to the dresserClient #2's bedroom cover. The ceiling fan The paint on the walls areas.	Il bathroom was missing. e hallway to the bathroom. the wall was damaged next areas of the walls damaged ades were covered in dust of the hallway on the right e inside the wood was The dresser was missing a had a hole in closet door. were off the rails and off s peeled away from the wall had a loose electrical socket a light was missing the globe. Is was peeled off in various	V 736				

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