Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE		(X3) DATE SURVEY COMPLETED		
AND FLAN	DI LAN OF CONNECTION		A. BUILDING: _		COMPLETE	<u>-</u> D
	MHL005019 B. WING			07/12/2023		
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	ODRESS, CITY, STAT	TE, ZIP CODE		
SUMMIT S	SUPPORT SERVICES OF	ASHE-LIGHTHOUS	E STREET SON, NC 28640			
(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 CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
V 000	INITIAL COMMENTS An annual and follow up survey was completed on July 12, 2023. Deficiencies were cited. This facility is licensed for the following service		V 000			
	category: 10A NCAC	27G .5600C Supervised Developmental Disability.				
	This facility is licensed for 6 and currently has a census of 6. The survey sample consisted of audits of 3 current clients.					
V 114	V 114 27G .0207 Emergency Plans and Supplies		V 114			
	10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES (a) A written fire plan for each facility and area-wide disaster plan shall be developed and shall be approved by the appropriate local authority. (b) The plan shall be made available to all staff and evacuation procedures and routes shall be posted in the facility. (c) Fire and disaster drills in a 24-hour facility shall be held at least quarterly and shall be repeated for each shift. Drills shall be conducted under conditions that simulate fire emergencies. (d) Each facility shall have basic first aid supplies accessible for use.					
	This Rule is not met as evidenced by: Based on record review and interview, the facility failed to conduct fire and disaster drills quarterly for each shift. The findings are:					
	Review on 7/12/23 of the facility's fire and disaster drill logs from July 2022 through June					

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

TITLE (X6) DATE Division of Health Service Regulation

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY PLETED
MHL005019			B. WING			/12/2023
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STA	TE, ZIP CODE		
SUMMIT SUPPORT SERVICES OF ASHE-LIGHTHOUS JEFFERSO			E STREET SON, NC 28640			
(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 CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
V 114	Continued From page 1 2023 revealed: -No documentation of fire drills for: -2nd Quarter - April - June 2023 - 1st shift; -3rd Quarter - December 2022 - 1st shift; -4th Quarter - October - December 2022 - 1st shift. -No documentation of disaster drills for: -2nd Quarter - April - June 2023 - 1st shift; -4th Quarter - October - December 2022 - 1st and 2nd shifts. Record review and Interview on 7/12/23 with the Assistant Director revealed: -The fire and disaster log had 3 shiftsConfirmed the drills were missing for the above quartersThe facility actually had 2 shifts as the Group Home Managers worked 12 hour shiftsShe would ensure this was more clear and drills were ran quarterly according to their shifts. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.		V 114			
V 367	10A NCAC 27G .0604 REPORTING REQUI CATEGORY A AND E (a) Category A and E level II incidents, exce the provision of billab consumer is on the princidents and level II	4 INCIDENT REMENTS FOR B PROVIDERS B providers shall report all ept deaths, that occur during le services or while the roviders premises or level III deaths involving the clients rendered any service within incident to the LME itchment area where	V 367			

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TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) V 367 Continued From page 2 becoming aware of the incident. The report shall be submitted on a form provided by the Secretary. The report may be submitted via mail, in person, facsimile or encrypted electronic means. The report shall include the following	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 120 ASHE STREET JEFFERSON, NC 28640 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) V 367 Continued From page 2 becoming aware of the incident. The report shall be submitted on a form provided by the Secretary. The report may be submitted via mail, in person, facsimile or encrypted electronic means. The report shall include the following			A. BUILDING: _				
SUMMIT SUPPORT SERVICES OF ASHE-LIGHTHOUS (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (EACH CORRECTIVE ACTION SHOULD BE DEFICIENCY) V 367 Continued From page 2 becoming aware of the incident. The report shall be submitted on a form provided by the Secretary. The report may be submitted via mail, in person, facsimile or encrypted electronic means. The report shall include the following	MHL005019		B. WING		07/12/2023		
SUMMIT SUPPORT SERVICES OF ASHE-LIGHTHOUS JEFFERSON, NC 28640 (X4) ID PREFIX TAG CEACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) V 367 Continued From page 2 becoming aware of the incident. The report shall be submitted on a form provided by the Secretary. The report may be submitted via mail, in person, facsimile or encrypted electronic means. The report shall include the following JEFFERSON, NC 28640 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE (EACH CORRECTION SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE (EACH CORRECTION SHOULD BE (EACH CORRECTION SHOULD BE (EACH CORRECTION SHOULD BE (EACH CORRECTION SHOULD BE (EA	NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STAT	TE, ZIP CODE			
X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) V 367 Continued From page 2 V 367 Decoming aware of the incident. The report shall be submitted on a form provided by the Secretary. The report may be submitted via mail, in person, facsimile or encrypted electronic means. The report shall include the following (EACH CORRECTIVE ACTION SHOULD BE (CROSS-REFERENCED TO THE APPROPRIATE DATE) COMPLET DATE CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY DATE CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY DATE	120 ASHE STREET						
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) V 367 Continued From page 2 becoming aware of the incident. The report shall be submitted on a form provided by the Secretary. The report may be submitted via mail, in person, facsimile or encrypted electronic means. The report shall include the following (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) V 367 V 367	SUMMIT SUPPORT SERVICES OF	- ASHE-LIGHTHOUS JEFFERS	ON, NC 28640				
becoming aware of the incident. The report shall be submitted on a form provided by the Secretary. The report may be submitted via mail, in person, facsimile or encrypted electronic means. The report shall include the following	PREFIX (EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF	D BE	COMPLETE	
be submitted on a form provided by the Secretary. The report may be submitted via mail, in person, facsimile or encrypted electronic means. The report shall include the following	V 367 Continued From pag	Continued From page 2					
(1) reporting provider contact and identification information; (2) client identification information; (3) type of incident; (4) description of incident; (5) status of the effort to determine the cause of the incident; and (6) other individuals or authorities notified or responding. (b) Category A and B providers shall explain any missing or incomplete information. The provider shall submit an updated report to all required report recipients by the end of the next business day whenever: (1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or (2) the provider obtains information required on the incident form that was previously unavailable. (c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including: (1) hospital records including confidential information; (2) reports by other authorities; and (3) the provider's response to the incident. (d) Category A and B providers shall send a copy of all level III incident reports to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of becoming aware of the incident. Category A	becoming aware of the submitted on a formation: (1) reporting provided information: (1) reporting provided information: (2) client identification information: (3) type of incitive incitive information: (4) description: (5) status of the cause of the incidentification information: (6) other indivition or responding. (b) Category A and I missing or incompleted shall submit an update report recipients by the day whenever: (1) the provided information provided erroneous, misleadire (2) the provided required on the incided unavailable. (c) Category A and I upon request by the obtained regarding the obtained	the incident. The report shall rm provided by the art may be submitted via mail, for encrypted electronic shall include the following rovider contact and attion; iffication information; dent; of incident; of incident; and iduals or authorities notified. B providers shall explain any the information. The provider atted report to all required the end of the next business for has reason to believe that in the report may be any or otherwise unreliable; or the obtains information ent form that was previously and providers shall submit, LME, other information the incident, including: cords including confidential cother authorities; and the providers shall send a copy to the providers shall send a copy to the providers of lopmental Disabilities and the ervices within 72 hours of	V 367				

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	MENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA LAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		
	MHL005019			B. WING			12/2023	
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE			
CUMMIT C	NUDDODT SEDVICES OF	ACUE LICUTUOUS	120 ASHE	STREET				
SUMMITS	SUPPORT SERVICES OF	ASHE-LIGHTHOUS	JEFFERSO	N, NC 28640				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		Y FULL PREFIX (EACH CORRECTIVE ACTION SHOW		OULD BE	(X5) COMPLETE DATE		
V 367	Continued From page	e 3		V 367				
	Health Service Regular becoming aware of the client death within service restraint, the provice immediately, as requiled. 0300 and 10A NCAC (e) Category A and Be report quarterly to the catchment area where The report shall be subly the Secretary via experimental include summary information of a level II of the definition of a level II of the defin	s providers shall send a LME responsible for the e services are provided. Ibmitted on a form provided electronic means and shormation as follows: errors that do not meet to revel III incident; Iterventions that do not real II or level III incident; Iterventions that do not real II or level III incident; Iterventions that do not real II or level III incident; Iterventions that do not real II or level III and level dient; Iterventions that do not real II or level III and level dient; Iterventions that there has cidents whenever no ed during the quarter that as set forth in Paragrape and Subparagraphs (1 ragraph.	sion e ded all the meet a; ty in IIII ve at aphs					
	Based on record revieus failed to ensure that in	ew and interview, the fac	-					

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	MENT OF DEFICIENCIES LAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	(X3) DATE SURVEY COMPLETED	
MHL005019			B. WING	07/12/2023	
	ROVIDER OR SUPPLIER	ASHE-LIGHTHOUS	ORESS, CITY, STA STREET ON, NC 28640	TE, ZIP CODE	
(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 CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE
V 367	-Admitted 11/21/16Diagnoses of Autism Intellectual Developm Obstructive Sleep Apropersion of Seizure Disorder, Post Constipation, Major Danxiety Disorder6/16/23 Individual Suthe client was approve the community. Review on 7/12/23 of -Admitted 12/5/16Diagnoses of Modera Hyperlipidemia, Iron Dafficiency6/22/23 Individual Suthe client was approve the community. Review on 7/12/23 of shift notes from May 2 revealed: -6/14/23 - incident repknocked on Client #1' answer. The bedroom Police called. Client rea.m6/17/23 - shift note walked down the road was returned home6/25/23 - incident rep"went out his bedroof	Client #1's record revealed: Spectrum Disorder, Mild ental Disability (IDD), nea, Hypercholesterolemia, stural Kyphosis, epressive Disorder and apport Plan did not indicate ed for unsupervised time in Client #2's record revealed: ate IDD, Mixed Deficiency-Anemia, and apport Plan did not indicate ed for unsupervised time in facility incident reports and 2023 through July 2023	V 367		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE COME			SURVEY PLETED	
		MHL005019	B. WING		07	//12/2023
	ROVIDER OR SUPPLIER	ASHE-LIGHTHOUS	DDRESS, CITY, STATE STREET SON, NC 28640	E, ZIP CODE		
(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 ACTIC CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
V 367	Review on 7/12/23 of Response Improvement -No level II reports we on 6/14/23 and 6/25/22 Interviews on 7/12/23 and the Assistant Director -The Risk Manager Compared to submit the IRIS republication of	the North Carolina Incident ent System (IRIS) revealed: ere submitted for Client #1 23; Client #2 on 6/17/23. with the Executive Director ector revealed: coordinator was responsible ports, but "I [Executive evel II IRIS report was enforcement was contacted	V 367			

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