Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					(X3) DATE SURVEY COMPLETED	
		IDENTIFICATION NUMBER.	A. BUILDING:			
		MHL078-309	B. WING			R / 28/2018
IAME OF P	ROVIDER OR SUPPLIER	STREET	DDRESS, CITY, STATE	, ZIP CODE		
AMERO	N HOME		TTON STREET RTON, NC 28358			
(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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	CTION SHOULD BE COMPLE O THE APPROPRIATE DATE	
V 000	INITIAL COMMENTS		V 000			
	An annual and follow up survey was completed on June 28, 2018. A deficiency was cited.					
	This facility is licensed for the following service category: 10A NCAC 27G .5600F Supervised Living/Alternative Family Living.					
V 290	27G .5602 Supervised Living - Staff		V 290			
	 10A NCAC 27G .5602 STAFF (a) Staff-client ratios above the minimum numbers specified in Paragraphs (b), (c) and (d) of this Rule shall be determined by the facility to enable staff to respond to individualized client needs. (b) A minimum of one staff member shall be present at all times when any adult client is on the premises, except when the client's treatment or habilitation plan documents that the client is capable of remaining in the home or community without supervision. The plan shall be reviewed as needed but not less than annually to ensure the client continues to be capable of remaining in the home or specified periods of time. (c) Staff shall be present in a facility in the following client-staff ratios when more than one child or adolescent client is present: (1) children or adolescents with substance abuse disorders shall be served with a minimum of one staff present for every five or fewer minor clients present. However, only one staff need be present during sleeping hours if specified by the emergency back-up procedures determined by 					
	the governing body; (2) children or developmental disab one staff present for	or adolescents with ilities shall be served with every one to three clients				
	emergency back-up p the governing body; o (2) children or developmental disab one staff present for present and two staff alth Service Regulation	procedures determined by or adolescents with ilities shall be served with	RE	TITLE		

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

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Division of Health Service Regulation STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL078-309					(X3) DATE SURVEY COMPLETED R 06/28/2018	
		IDENTIFICATION NOWBER.				
		B. WING				
NAME OF PI	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE		
CAMERO	N HOME		TTON STREET RTON, NC 28358			
(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 COMPLE O THE APPROPRIATE DATE	
V 290	Continued From page	e 1	V 290			
	 more clients present. However, only one staff need be present during sleeping hours if specified by the emergency back-up procedures determined by the governing body. (d) In facilities which serve clients whose primary diagnosis is substance abuse dependency: (1) at least one staff member who is on duty shall be trained in alcohol and other drug withdrawal symptoms and symptoms of secondary complications to alcohol and other drug addiction; and (2) the services of a certified substance abuse counselor shall be available on an as-needed basis for each client. 					
	facility did not ensure habilitation plans doc capable of remaining	ew and interviews, the clients' treatment or sumented the clients were in the community without two of two clients (#1 and				
		06/11/87. Plan (ISP) dated 05/01/18. client #1 was able to remain				
	Review on 06/28/18 of revealed; - 36 year old male. - Admission date of 0 - ISP dated 02/06/18 - No documentation of alth Service Regulation)3/01/91.				

STATE FORM

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X		
		IDENTIFICATION NOMBER.	A. BUILDING:		COMPLETED	
		MHL078-309	B. WING		06	6/28/2018
IAME OF PF	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE,	ZIP CODE		
AMERON	NHOME		TTON STREET RTON, NC 28358			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED T(DEFICIE	CTION SHOULD BE COMPLE D THE APPROPRIATE DATE	
V 290	Continued From page 2		V 290			
	in the community without supervision.					
	the community colleg Thursday. - Client #2 rode the lo his day program daily - Staff do not accomp on the local transport Interview on 06/28/18 (QP) stated: - She understood clie to have unsupervised local transportation s supervision. - She would assess a transportation and un treatment teams for o revise the ISPs/comp the unsupervised tim	 bocal transportation system to ge weekly on Tuesday and bocal county transportation to y. boany client #1 and client #2 tation system. 8 the Qualified Professional ent #1 and client #2 needed d time in their ISP to ride the system without staff and address the nsupervised time with the client #1 and client #2 and oblete addendums to reflect te. 				

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