	of Health Service Regu	ulation			FUR	M APPRO
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C	(X3) DATE	(X3) DATE SURVEY		
		DENTIFICATION NUMBER:	A. BUILDING:	COMP	COMPLETED	
		MIII 884 445	B 14/11/0			
		MHL024-103	B. WING	,	07/	11/2018
IAME OF PR	ROVIDER OR SUPPLIER	STREET	DDRESS, CITY, STATE	E, ZIP CODE		
INEWOO	D HOUSE	817 PINE	WOOD DRIVE			
		WHITEV	ILLE, NC 28472			
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID	PROVIDER'S PLAN OF CORREC		(X5)
TAG			PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR		COMPLET
		•	143	DEFICIENCY)	OPRIALE	DATE
V 000	INITIAL COMMENTS		V 000			
	THE COMMENTS		V 000			
- 1	An annual survey was	completed on July 11,				
	2018. A deficiency was	as cited.				
	This facility is licensed	for the following service				
	category: 10A NCAC 2	27G .5600C Supervised				
1	Living for Adults with D	Developmental Disabilities.				
V 289	27G .5601 Supervised	Living - Scope	V 289			
1	10A NCAC 27G .5601	SCOPE	1 1		2	
		s a 24-hour facility which			,	
	provides residential se	rvices to individuals in a				
∣i	home environment whe	ere the primary purpose of			Í	
t	these services is the ca	are, habilitation or			1	
r	rehabilitation of individu	uals who have a mental				
ļ i!	Ilness, a developmenta	al disability or disabilities,			1	
C	or a substance abuse of	disorder, and who require	1			
9	supervision when in the	e residence.			1	
((b) A supervised living	facility shall be licensed if				
1	he facility serves either one or more r				1	
	2) two or more a	minor clients; or		RECEIVE	D	
	Minor and adult clients	shall not reside in the		RECEIVE		
s	ame facility.	shall not leside in the		200	40	
	c) Each supervised liv	ing facility shall be		JUL 2 3 20	13	
l lie	censed to serve a spec	cific population as				
0	lesignated below:			DHSR-MH Licens	ure Sect	
	 "A" designatio 	n means a facility which			1	
ii	erves adults whose pri	mary diagnosis is mental				
	iness but may also hav	e other diagnoses;			1	
(2	2) "B" designatio	n means a facility which				
di di (3	erves minors whose pr	mary diagnosis is a			ĺ	
	evelopmental disability iagnoses;	but may also have other				
		n means a facility which				
	erves adults whose prin	mary diagnosis is s				
d€	evelopmental disability	but may also have other				
di	agnosso:	y wide ilaye outer				
di	agnoses;	1	1			

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

STATE FORM

BOOR BUJP

(XB) DATE

If continuation sheat 1 of 3

Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CL/A (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING_ MHL024-103 07/11/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 817 PINEWOOD DRIVE PINEWOOD HOUSE WHITEVILLE, NC 28472 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY V 289 Continued From page 1 V 289 serves minors whose primary diagnosis is substance abuse dependency but may also have other diagnoses; "E" designation means a facility which serves adults whose primary diagnosis is substance abuse dependency but may also have other diagnoses; or "F" designation means a facility in a private residence, which serves no more than three adult clients whose primary diagnoses is mental illness but may also have other disabilities, or three adult clients or three minor clients whose primary diagnoses is developmental disabilities but may also have other disabilities who live with a family and the family provides the service. This facility shall be exempt from the following rules: 10A NCAC 27G .0201 (a)(1),(2),(3),(4),(5)(A)&(B); (6); (7) (A),(B),(E),(F),(G),(H); (8); (11); (13); (15); (16); (18) and (b); 10A NCAC 27G .0202(a),(d),(g)(1) (i); 10A NCAC 27G .0203; 10A NCAC 27G .0205 (a),(b); 10A NCAC 27G .0207 (b),(c); 10A NCAC 27G .0208 (b),(e); 10A NCAC 27G .0209[(c)(1) non-prescription medications only] (d)(2),(4); (e) (1)(A),(D),(E);(f);(g); and 10A NCAC 27G .0304 (b)(2),(d)(4). This facility shall also be known as alternative family living or assisted family living (AFL). This Rule is not met as evidenced by: Based on record review and interview, the facility failed to operate within the scope of licensure by serving one of three audited clients (#1) without a primary diagnosis of Developmental Disability. The findings are: Review on 07/10/18 of Division of Health Service

Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: MHL024-103 07/11/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 817 PINEWOOD DRIVE **PINEWOOD HOUSE** WHITEVILLE, NC 28472 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) V 289 | Continued From page 2 V 289 Regulation (DHSR) records revealed the facility is licensed under 10A NCAC 27G .5600C, Supervised Living for Adults with Developmental Disabilities. Review on 07/11/18 of client #1's record revealed: - 53 year old male. - Admission date of 09/01/16. - Diagnosis of Schizophrenia Disorder, Autism Spectrum Disorder, Pervasive Speech with Delayed Echolalia, Hearing Loss Right Ear. Peripheral Retinal Degeneration Disorder, Myopia and Exotropia. Interview on 07/11/18 client #1 stated he had transitir (to a new group home. resided at the facility for several years. Interview on 07/11/18 the Licensee stated: - She did not have a current waiver for client #1 to remain at the facility. - She would explore with the Local Management Entity/Managed Care Organization regarding a waiver for client #1 to remain in the facility.

· EOI 120 7HW Jay COMMENTS: Plan of Correction TOTAL # OF PAGES, INCLUDING COVER SHEET: CEOR YOUR INFO. PLEASE REVIEW REPLY ASAP DRCENT Circle One: COLE 249016 8L08 SIL 616 Phone Number: Eax Mumber: 81-5C-L Licensure Attention: MSCADIO NGDHHZ H.LOID: Company Name:

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Phone: 910-642-3700; Fax: 910-642-5146 Whiteville, NC 28472 P.O. Box 1723 Carolinas Home Care Agency, Inc.

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Phone: 910-642-3700; Fax: 910-642-5146

FACSIMILIE COVER SHEET

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Company Name:	From:
NCDHHS Cicensure Attention:	Terry Smith Date:
Licensure Section Fax Number:	7-25-18 Phone Number:
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