| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | | | (X3) DATE COMP | | |
|---|--|---|---------------------|--|-------|--------------------------|
| | | MHL064-107 | B. WING | | 08/1 | 2 4/2018 |
| NAME OF F | PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, S | STATE, ZIP CODE | | |
| TYL(TH | IANK YOU LORD) | _* | STEAD ROA | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | _D BE | (X5) COMPLETE DATE |
| V 000 | INITIAL COMMENT | -S | V 000 | | | |
| | on 8/14/18. Deficier This facility is licens | sed for the following service C 27G. 5600F Supervised | | | | |
| V 112 | 10A NCAC 27G .02 TREATMENT/HABI PLAN (c) The plan shall be assessment, and in legally responsible of admission for clie receive services be (d) The plan shall in (1) client outcome(achieved by provision projected date of acceptance (2) strategies; (3) staff responsible (4) a schedule for a cannually in consultar responsible person (5) basis for evaluation outcome achievement (6) written consent responsible party, consultar responsible party, cons | nclude: s) that are anticipated to be on of the service and a chievement; e; review of the plan at least ation with the client or legally or both; ation or assessment of | V 112 | | | |

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE (X6) DATE TITLE

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION (X3) DATE 3 COMPL | | SURVEY PLETED | | |
|---|--|--|---------------------|--|---------------------|--------------------------|
| MHL064-107 | | B. WING | | | R 14/2018 | |
| NAME OF | PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, S | STATE, ZIP CODE | | |
| TYL(T | ANK YOU LORD) | _*:= ::::: | STEAD ROA | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOTH CROSS-REFERENCED TO THE APPROPRIES OF THE APP | ULD BE | (X5) COMPLETE DATE |
| V 112 | Continued From pa | ge 1 | V 112 | | | |
| | failed to ensure 1 o was revised. The find Review on 8/9/18 or admitted to the diagnoses of Schizorder; Hypertens Diabetes Mellitus II Review on 8/9/18 or client #2 revealed: no goals in regards. | view and interview the facility f 3 clients (#2) treatment plan ndings are: f client #2's record revealed: facility on 12/1/11 chizophrenia; Psychotic sion; Seizure Disorder; and High Cholesterol f a 9/28/17 treatment plan for ards to drinking alcohol ion throughout the treatment | | | | |
| | he will drink a 4awhilehe rode his bike | 8/9/18 client #2 reported: 40 oz beer every once in to the store to get the beer the beer at the facility | | | | |
| | - he has found e the yard and in cliet - sometimes afte downwhich conce seizures and it was a seizure or intoxica - the last diagnos - he does not ext behaviors when he - he explain/cour alcohol with his me - his physicians a - client #2 drinks | er drinking client #2 would fall erned him because he has difficult to tell if he was having ated sed seizure was 2 years ago hibit any verbal or physical drinks nsel client#2 about drinking | | | | |

Division of Health Service Regulation

STATE FORM 6899 IOT011 If continuation sheet 2 of 6

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION (X3) DATE SI A. BUILDING: | | | | |
|---|--|---|---|--|-------------|--------------------------|
| MHL064-107 | | | B. WING | | | R 1 4/2018 |
| NAME OF PROVIDER OR SUPPLIER TYL (THANK YOLLL ORD) STREET AD 2612 WIN | | | DRESS, CITY, S' STEAD ROAL OUNT, NC 2 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | N SHOULD BE | (X5) COMPLETE DATE |
| V 112 | Professional was tr she has filled ir - she was not aw drinking was discus - as she recalled exhibited no behavi - client #2 still ne | n until the Qualified ained n for the last month vare client #2 drink but his esed in 2017 he did not drink often and | V 112 | | | |
| V 290 | numbers specified of this Rule shall be enable staff to resp needs. (b) A minimum of compresent at all times premises, except whabilitation plan docapable of remaining without supervision as needed but not I the client continues the home or commispecified periods of (c) Staff shall be profollowing client-staff child or adolescent (1) children of abuse disorders should one staff present clients present. | so STAFF os above the minimum in Paragraphs (b), (c) and (d) e determined by the facility to ond to individualized client one staff member shall be when any adult client is on the then the client's treatment or cuments that the client is ing in the home or community. The plan shall be reviewed ess than annually to ensure to be capable of remaining in unity without supervision for fitme. | V 290 | | | |

Division of Health Service Regulation

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED | |
|---|--|--|--|--|-------------------------------|--------------------------|
| MHL064-107 | | B. WING | | | R 08/14/2018 | |
| NAME OF F | PROVIDER OR SUPPLIER | | | STATE, ZIP CODE | 1 00/1 | 4/2010 |
| | | | STEAD ROA | , | | |
| TYL(TF | IANK YOU LORD) | ROCKY M | OUNT, NC | 27804 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | .D BE | (X5) COMPLETE DATE |
| V 290 | developmental disa one staff present for present and two star more clients present need be present duspecified by the emdetermined by the gradient of the grad | c; or radolescents with bilities shall be served with revery one to three clients aff present for every four or at. However, only one staff ring sleeping hours if ergency back-up procedures governing body. The serve clients whose primary nee abuse dependency: the staff member who is one do in alcohol and other drug and symptoms of ations to alcohol and other drug and symptoms of ations to alcohol and other drug and symptoms of ations to alcohol and other drug and symptoms of ations to alcohol and other drug and symptoms of ations to alcohol and other drug and symptoms of ations to alcohol and other drug and symptoms of ations to alcohol and other drug and symptoms of ations to alcohol and other drug and symptoms of ations to alcohol and other drug and interview the facility hinimum of one staff member are except when the client's amented the client was ang in the home or community 2 & #3). The findings are: Itag (V112). 10A NCAC 27G NT AND ANCAC 27G NT AND ANC | V 290 | | | |
| | Review on 8/9/18 o | f client #2's record revealed: | | | | |

Division of Health Service Regulation

admitted to the facility on 12/1/11

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X1) PROVIDER/SUPPLIER/CLIA | | | | OATE SURVEY COMPLETED | |
|---|--|-----------------------------|--------------------------|---|-------|--------------------------|--|
| | | | | R | | | |
| | | MHL064-107 | B. WING | <u></u> | 08/1 | 4/2018 | |
| NAME OF | PROVIDER OR SUPPLIER | | | STATE, ZIP CODE | | | |
| TYL(TH | IANK YOU LORD) | | STEAD ROA IOUNT, NC : | | | | |
| (X4) ID | SUMMARY STA | TEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF CORRECTI | ON | (X5) | |
| PREFIX TAG | | | PREFIX TAG | (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | _D BE | COMPLETE DATE | |
| V 290 | Continued From page 4 | | V 290 | | | | |
| | - diagnoses of Schizophrenia; Psychotic Disorder; Hypertension; Seizure Disorder; Diabetes Mellitus II and High Cholesterol - a treatment plan dated 9/8/17 with no documentation of unsupervised time in home/community During interview on 8/9/18 client #2 reported: - he will drink a 40 oz beer every once in awhile - he rode his bike to the store to get the beer - he would drink the beer at the facility - he has unsupervised time in the facility and community During interview on 8/10/18 the Program Manager reported: - client #2 only has 2 hours of unsupervised time - 1 hour in the community and 1 hour in the facility During interview on 8/8/18 & 8/14/18 the Licensee reported: - client #2's unsupervised time was reduced to 2 hours daily - the Local Managed Entity/Managed Care Organization reduced it last year due to concerns of his drinking B. Review on 8/9/18 of client #3's record revealed: - admitted to the facility on 12/13/17 - diagnoses of Mild Mental Retardation; Autism and Hypercholestorlemia - a treatment plan dated 12/12/17 with no goals of unsupervised time During interview on 8/9/18 client #3 reported: - he walked to the local gas station without | | | | | | |
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STATE FORM 6899 IOT011 If continuation sheet 5 of 6

| MHL084-107 STREET ADDRESS, CITY, STATE, ZIP CODE 2612 WINSTEAD ROAD ROCKY MOUNT, NC 27804 | STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | | | | (3) DATE SURVEY COMPLETED | |
|--|---|--|---|--------------|---|------------------------------|----------|
| NAME OF PROVIDER OR SUPPLIER TYL (THANK YOU LORD) 2612 WINSTEAD ROAD ROCKY MOUNT, NC 27804 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) V 290 Continued From page 5 staff - he will walk on the local natural trail - he does not go out in the community often During interview on 8/14/18 the Licensee reported: - client #3 has unsupervised time in the home | | | | | | | |
| TYL (THANK YOU LORD) ROCKY MOUNT, NC 27804 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) V 290 Continued From page 5 staff - he will walk on the local natural trail - he does not go out in the community often During interview on 8/14/18 the Licensee reported: - client #3 has unsupervised time in the home | | | MHL064-107 | B. WING | | 08/1 | 4/2018 |
| Cach Deficiency Must be preceded by Full Regulatory or Lsc identifying information Cach Deficiency | NAME OF | PROVIDER OR SUPPLIER | | | | | |
| (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) V 290 Continued From page 5 Staff | TYL(T | HANK YOU LORD) | | | | | |
| staff - he will walk on the local natural trail - he does not go out in the community often During interview on 8/14/18 the Licensee reported: - client #3 has unsupervised time in the home | PREFIX | ID SUMMARY STATEMENT OF DEFICIENCIES FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL | | ID PREFIX | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO | _D BE | COMPLETE |
| | V 290 | staff - he will walk on - he does not go During interview on reported: - client #3 has ur | the local natural trail out in the community often 8/14/18 the Licensee | V 290 | | | |

6899

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