| | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | PLETED |
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| MHL041-057 | B. WING | | 08/10/2018 | |
| | L DRESS, CITY, S | TATE, ZIP CODE | 00/10/2010 | |
| I CREST HOUSE | | | | |
| 4) ID SUMMARY STATEMENT OF DEFICIENCIES | BORO, NC 27 | PROVIDER'S PLAN OF C | | (X5) |
| AFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL AG REGULATORY OR LSC IDENTIFYING INFORMATION) | PREFIX TAG | (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY | ON SHOULD BE HE APPROPRIATE | COMPLET DATE |
| ✓ 000 INITIAL COMMENTS | V 000 | | | |
| An annual survey was completed on 8-10-2018. A deficiency was cited. | | | | |
| This facility is licensed for the following service category: 10A NCAC 27G .5600A Supervised Living for Adults with Mental Illness. | | | | |
| ✓ 289 27G .5601 Supervised Living - Scope | V 289 | | | |
| 10A NCAC 27G .5601 SCOPE (a) Supervised living is a 24-hour facility which provides residential services to individuals in a home environment where the primary purpose of these services is the care, habilitation or rehabilitation of individuals who have a mental illness, a developmental disability or disabilities, or a substance abuse disorder, and who require supervision when in the residence. (b) A supervised living facility shall be licensed if the facility serves either: (1) one or more minor clients; or (2) two or more adult clients. Minor and adult clients shall not reside in the same facility. (c) Each supervised living facility shall be licensed to serve a specific population as designated below: (1) "A" designation means a facility which serves adults whose primary diagnosis is mental illness but may also have other diagnoses; (2) "B" designation means a facility which serves adults whose primary diagnosis is a developmental disability but may also have other diagnoses; (3) "C" designation means a facility which serves adults whose primary diagnosis is a developmental disability but may also have other diagnoses; (4) "D" designation means a facility which | | | | |

| | STATEMENT OF DEFICIENCIES(X1) PROVIDER/SUPPLIER/CLIAAND PLAN OF CORRECTIONIDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | | |
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| | | A. DOILDING | | | | |
| MHL041-057 | | B. WING | | 08/10/2018 | | |
| AME OF PROVIDER OR SUPPLIEF | | | TATE, ZIP CODE | | | |
| IILLCREST HOUSE | | ST FRIENDLY BORO, NC 27 | | | | |
| PREFIX (EACH DEFICIENC | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC | TION SHOULD BE THE APPROPRIATE | (X5) COMPLET DATE | |
| V 289 Continued From p | age 1 | V 289 | | · | | |
| substance abuse other diagnoses; (5) "E" desig serves adults who substance abuse other diagnoses; o (6) "F" desig private residence, three adult clients mental illness but disabilities, or three clients whose prim developmental dis other disabilities w family provides the exempt from the f .0201 (a)(1),(2),(3) (A),(B),(E),(F),(G) (18) and (b); 10A (i); 10A NCAC 270 (a),(b); 10A NCAC 27G .0208 (b),(e); non-prescription (1)(A),(D),(E);(f);(g (b)(2),(d)(4). This alternative family f (AFL). | ynation means a facility in a which serves no more than whose primary diagnoses is may also have other se adult clients or three minor | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL041-057 | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED 08/10/2018 | | |
|-------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|-------------------------------|-------------------------------------------------------------------------------|-----------------------------------|-------------------------|
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| | | | BRESS, CITT, S ST FRIENDLY | | | |
| HILLCRE | EST HOUSE | | BORO, NC 27 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC | TION SHOULD BE THE APPROPRIATE | (X5) COMPLET DATE |
| V 289 | Continued From pa | ige 2 | V 289 | | | |
| | disorder, and who r | ties, or a substance abuse require supervision when in the 2 of 2 former clients (FC #1 indings are: | | | | |
| | facility from 5/1/201 - An incident report was found in facility - 7/28/2018 inciden - "[FC #2] ran out of and did not have ar - "The pharmacy ha | ad to order these eye drops for able to pick them up till the | | | | |
| | Records (MAR) from - Current MARS for | 3 of Medication Administration m 8/1/2018-8/8/2018 revealed: FC #1 and FC #2 were ogram Director and were y. | | | | |
| | Program Director re - FC #1 lived in the time he moved to a he lived until 3/30/2 - FC #1 currently re by facility staff: - His controlled mean morning. | facility until 2006 at which n apartment next door where | | | | |
| | there is something them later." - "calls us in the medications" - "We are here for s - All medications ar - Money manageme | going on and I or staff count morning when he takes his symptom management." | | | | |

Division of Hea STATE FORM

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| Division of Health Service Regulation STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL041-057 | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED | | |
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| | | MHI 041-057 | B. WING | | 08/10/2018 | |
| IAME OF | PROVIDER OR SUPPLIER | | DDRESS, CITY, S | TATE, ZIP CODE | | |
| IILLCRE | EST HOUSE | | ST FRIENDLY BORO, NC 27 | | | |
| (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 (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN | TION SHOULD BE THE APPROPRIATE | (X5) COMPLET DATE |
| V 289 | Continued From pa | age 3 | V 289 | | | |
| | services" to FC #1. - Reported FC #1's - FC #2 lived in the 1/16/2017 at which condominium. - FC #2 currently re by facility staff: - She came to facil medication, "just lik - When medication she calls us." - Attended monthly #2. - "We are here for = - Privately paid to p services" to FC #2 - Reported FC #2's - Reported FC #2, | brovide "supported living MARs were kept at facility. facility until her discharge on time she moved into a ecceives the following services ity in the morning to take her ke everyone who lives here." is taken in the evening, " medical appointments with FC symptom management." provide "supported living | | | | |

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