STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL026-299	A. BUILDING: _____ B. WING _____	R 08/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANBERRY PLACE	**1909 STANBERRY PLACE FAYETTEVILLE, NC 28301**

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 000	INITIAL COMMENTS An annual and follow up survey was completed on August 23, 2018. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600A Supervised Living for Adults with Mental Illness.	V 000		
V 111	27G .0205 (A-B) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (a) An assessment shall be completed for a client, according to governing body policy, prior to the delivery of services, and shall include, but not be limited to: (1) the client's presenting problem; (2) the client's needs and strengths; (3) a provisional or admitting diagnosis with an established diagnosis determined within 30 days of admission, except that a client admitted to a detoxification or other 24-hour medical program shall have an established diagnosis upon admission; (4) a pertinent social, family, and medical history; and (5) evaluations or assessments, such as psychiatric, substance abuse, medical, and vocational, as appropriate to the client's needs. (b) When services are provided prior to the establishment and implementation of the treatment/habilitation or service plan, hereafter referred to as the "plan," strategies to address the client's presenting problem shall be documented.	V 111		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL026-299	A. BUILDING: _____ B. WING _____	R 08/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANBERRY PLACE	1909 STANBERRY PLACE FAYETTEVILLE, NC 28301

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 111	Continued From page 1	V 111		

This Rule is not met as evidenced by:
Based on record review and interview, the facility failed to complete an assessment and strategies to address the client's presenting problems prior to the delivery of services for 1 of 3 clients audited (client #1). The findings are:

Review of client #1's record on 8/22/18 - 8/23/18 revealed:
-33 year old male admitted 5/15/18 from a psychiatric hospital where he had been an inpatient from 1/5/18 - 5/15/18.
-Diagnoses included Schizoaffective disorder; Intermittent Explosive Disorder; Moderate Mental Retardation; Anemia; Hypertension; Obesity' Vitamin D Deficiency; Dry Mouth, Urinary Incontinence.
-Risk/Support Needs Assessment dated 5/22/18.
-Service Plan dated 6/12/18.
-No documentation of an assessment and strategies to address the client's presenting problems prior to the delivery of residential services.

Client #1 declined to be interviewed on 8/23/18.

Interview on 8/23/18 the Qualified Professional (QP) stated:
-The QP at the time client #1 was admitted was no longer employed.
-She was not able to locate an admission assessment or strategies to address client #1's presenting problems and needs prior to the plan dated 6/12/18.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL026-299	A. BUILDING: _____ B. WING _____	R 08/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANBERRY PLACE	1909 STANBERRY PLACE FAYETTEVILLE, NC 28301

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 112	Continued From page 2	V 112		
V 112	27G .0205 (C-D) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (c) The plan shall be developed based on the assessment, and in partnership with the client or legally responsible person or both, within 30 days of admission for clients who are expected to receive services beyond 30 days. (d) The plan shall include: (1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement; (2) strategies; (3) staff responsible; (4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both; (5) basis for evaluation or assessment of outcome achievement; and (6) written consent or agreement by the client or responsible party, or a written statement by the provider stating why such consent could not be obtained. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to develop and implement strategies based on assessment affecting 2 of 3 clients audited (clients #1, #3). The findings are:	V 112		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL026-299	A. BUILDING: _____ B. WING _____	R 08/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANBERRY PLACE	1909 STANBERRY PLACE FAYETTEVILLE, NC 28301

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 112	Continued From page 3 Finding #1: Review of client #1's record on 8/22/18 - 8/23/18 revealed: -33 year old male admitted 5/15/18 from a psychiatric hospital where he had been an inpatient from 1/5/18 - 5/15/18. -Diagnoses included Schizoaffective disorder; Intermittent Explosive Disorder; Moderate Mental Retardation; Anemia; Hypertension; Obesity' Vitamin D Deficiency; Dry Mouth, Urinary Incontinence. Review on 8/22/18 of client #1's Risk/Support Needs Assessment dated 5/22/18 revealed: -"[Client #1] has a history of sabotaging residential placements due to property destruction and verbal aggression; and ultimately returning back to hospitalization." Review on 8/22/18 and 8/23/18 of client #1's "Assessment Addendum" by the consulting Psychologist revealed: -"[Client #1] has a history of verbal and physical aggressiveness towards peers and staff..." -"[Client #1] has been diagnosed with severe behavioral problems." Review on 8/23/18 of client #1's Service Plan dated 6/12/18 revealed: -No goals or strategies for the prevention of verbal and physical aggressiveness towards peers and staff. -No goals or strategies for the prevention of property destruction. -The plan had not been signed by his guardian or other members of his treatment team. Client #1 declined to be interviewed on 8/23/18 at 12:00 pm.	V 112		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL026-299	A. BUILDING: _____ B. WING _____	R 08/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANBERRY PLACE	1909 STANBERRY PLACE FAYETTEVILLE, NC 28301

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 112	Continued From page 4 Finding #2: Review on 8/22/18 and 8/23/18 of client #3's record revealed: -35 year old male admitted 12/15/12. -Diagnoses included Bipolar Disorder, Schizophrenia, and Moderate Mental Retardation. Review on 8/22/18 of client #3's "Medical Consult Form" dated 6/1/18 and 7/2/18 revealed: -6/1/18 physician documented, "Blood pressure still not under control... Patient did not comply with bringing blood pressure check... Provided patient and caregiver with log & will bring log in next visit. Check BP daily." -7/2/18 physician documented, "...Please bring me the blood pressure and pulse readily next time." Interview on 8/23/18 client #3 stated: -Staff had started taking his blood pressure every day. -He did not take a list of his blood pressures to his last doctor's visit. -He could not remember the doctor's name. The doctor had asked them to take his blood pressure and bring the list with them, but it did not happen. They forgot and left the list at the group home. Review on 8/23/18 of client #3's Service Plan dated 5/28/18 revealed: -No goals or strategies for client #3's blood pressure checks and compliance with taking his log to physician office visits. Interview on 8/23/18 the Qualified Professional (QP) stated: -The QP employed when client #1 was admitted and participated in the Risk/Support Needs Assessment dated 5/22/18 was no longer employed by the facility.	V 112		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL026-299	A. BUILDING: _____ B. WING _____	R 08/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANBERRY PLACE	1909 STANBERRY PLACE FAYETTEVILLE, NC 28301

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 112	Continued From page 5 -She was able to locate client #1's plan dated 6/12/18 on the computer. She had no way of knowing if the clients guardian had participated in the development and approval of the plan. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 112		
V 118	27G .0209 (C) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (c) Medication administration: (1) Prescription or non-prescription drugs shall only be administered to a client on the written order of a person authorized by law to prescribe drugs. (2) Medications shall be self-administered by clients only when authorized in writing by the client's physician. (3) Medications, including injections, shall be administered only by licensed persons, or by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer medications. (4) A Medication Administration Record (MAR) of all drugs administered to each client must be kept current. Medications administered shall be recorded immediately after administration. The MAR is to include the following: (A) client's name; (B) name, strength, and quantity of the drug; (C) instructions for administering the drug; (D) date and time the drug is administered; and (E) name or initials of person administering the drug. (5) Client requests for medication changes or checks shall be recorded and kept with the MAR file followed up by appointment or consultation	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL026-299	A. BUILDING: _____ B. WING _____	R 08/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANBERRY PLACE	1909 STANBERRY PLACE FAYETTEVILLE, NC 28301

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 118	Continued From page 6 with a physician. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to administer medications as ordered by the physician and maintain an accurate MAR affecting 2 of 3 clients audited (clients #1, #3). The findings are: Finding #1: Review of client #1's record on 8/22/18 - 8/23/18 revealed: -33 year old male admitted 5/15/18 from a psychiatric hospital where he had been an inpatient from 1/5/18 - 5/15/18. -Diagnoses included Schizoaffective disorder; Intermittent Explosive Disorder; Moderate Mental Retardation; Anemia; Hypertension; Obesity' Vitamin D Deficiency; Dry Mouth, Urinary Incontinence. -FL-2 order dated 5/14/18 for Vitamin D 50,000 units every 4 weeks. -FL-2 order dated 5/14/18 for Biotene gel at bedtime. -No orders documented to discontinue Vitamin D or Biotine gel. Review on 8/21/18 of client #1's primary care office visit summary dated 7/19/18 revealed: -Medications documented on the summary as current medications included the that were not currently being administered to client #1 included: Clonazepam (anti-anxiety), Nuedexta (outburst of crying/laughing), Escitalopram (anti-depression), Olanzapine (anti-psychotic), Oxybutynin (incontinence), Tamsulosin (improve urination),	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL026-299	A. BUILDING: _____ B. WING _____	R 08/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANBERRY PLACE	1909 STANBERRY PLACE FAYETTEVILLE, NC 28301

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 118	Continued From page 7 and Zonisamide (anti-seizure). -Office visit summary did not include Vitamin D or Biotene gel as a current medication (both ordered 5/14/18). Review on 8/21/18 of client #1's MARs for July and August revealed: -No order transcribed for Vitamin D 50,000 units or Biotene gel at bedtime. -No documentation client had receive Vitamin D 50,000 units or Biotene since admission. Client #1 declined to be interviewed on 8/23/18 at 12:00 pm. Interview on 8/22/18 the Group Home Manager stated: -He recalled 1 vitamin pill had been sent with client #1 from the psychiatric hospital. He had been given this medication. -Client #1 had been taken to his psychiatrist on 5/22/18 and neither Vitamin D 50,000 units or Biotene gel had been ordered; therefore, the medications had not been continued. -There had been no discontinue orders for Vitamin D or Biotene gel. -He was not sure if the staff took client #1's current medication list or FL2 dated 5/14/18 to his primary care physician appointment on 7/19/18. -He was aware the psychiatric hospital doctor had diagnosed client #1 with urinary incontinence. Client #1 had 1 episode or urinary incontinence since his admission on 5/15/18. -He would follow up with the client #1's primary care physician to clarify orders listed and current orders for the client. Finding #2: Review on 8/22/18 and 8/23/18 of client #3's record revealed:	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL026-299	A. BUILDING: _____ B. WING _____	R 08/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANBERRY PLACE	1909 STANBERRY PLACE FAYETTEVILLE, NC 28301

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 118	Continued From page 8 -35 year old male admitted 12/15/12. -Diagnoses included Bipolar Disorder, Schizophrenia, and Moderate Mental Retardation. -Order dated 2/2/18 for Myrbetriq 50 mg (milligrams), daily. (Overactive bladder) -Order dated 2/2/18 for Hydralazine 50 mg at bedtime. (Treat high blood pressure) -Order dated 6/1/18 for Lisinopril 10 mg daily. (Lowers blood pressure) Review on 8/21/18 of client #3's MARs revealed: -Myrbetriq 50 mg scheduled to be administered daily at 8:00 am. No documentation Myrbetriq 50 mg had been administered on 7/31/18. -Hydralazine 50 mg scheduled to be administered at 8:00 pm daily. No documentation Hydralazine 50 mg had been administered on 7/1/18. Review on 8/22/18 of client #3's "Medical Consult Form" dated 6/1/18 and 7/2/18 revealed: -6/1/18 physician documented, "Blood pressure still not under control... Patient did not comply with bringing blood pressure check... Added Lisinopril 10 mg continue on other medications. Provided patient and caregiver with log & will bring log in next visit. Check BP daily." -7/2/18 physician documented, "...Please bring me the blood pressure and pulse readily next time" Review on 8/23/18 of client #3's daily blood pressures for July and August 2018 revealed: -July 2018: No blood pressures documented for 7/8/18, 7/15/18, 7/22/18, 7/28/18, 7/29/18, 7/31/18. -August 2018: No blood pressures documented for: 8/5/18, 8/12/18, August 20-23, 2018. Interview on 8/23/18 client #3 stated: -Staff always gave him his medications.	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL026-299	A. BUILDING: _____ B. WING _____	R 08/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANBERRY PLACE	1909 STANBERRY PLACE FAYETTEVILLE, NC 28301

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 118	Continued From page 9 -Staff had started taking his blood pressure every day. -He did not take a list of his blood pressures to his last doctor's visit. -He could not remember the doctor's name. The doctor had asked them to take his blood pressure and bring the list with them, but it did not happen. They forgot and left the list at the group home. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 118		
V 543	27F .0105(d) Client Rights - Client's Personal Funds 10A NCAC 27F .0105 CLIENT'S PERSONAL FUNDS (d) Authorization by the client or legally responsible person is required before a deduction can be made from a personal fund account for any amount owed or alleged to be owed for damages done or alleged to have been done by the client: (1) to the facility; (2) an employee of the facility; (3) to a visitor of the facility; or (4) to another client of the facility. This Rule is not met as evidenced by: Based on record review, observations, and interviews, the facility failed to receive authorization by the client or legally responsible person before a deduction was made from client's personal fund account for any amount owed or alleged to be owed for damages done by the client for one of three clients (client #2). The findings are:	V 543		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL026-299	A. BUILDING: _____ B. WING _____	R 08/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANBERRY PLACE	1909 STANBERRY PLACE FAYETTEVILLE, NC 28301

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 543	Continued From page 10 Review on 8/21/18 of client #2's record revealed: - 40 year old male admitted on 10/21/11. - Diagnoses: Impulse Disorder and Mild Intellectual Developmental Disabilities. - He is legally incompetent and has a guardian. Observation on 8/21/18 at approximately 10:45 am of client #2's room revealed: - The bedroom walls had approximately 3 - 4 total unpainted patched approximately softball-sized areas within the room. - Bedroom door had an approximate 1 foot square wooden panel patched onto top left section of the door. - Hallway wall leading to client #2's room had an unpainted approximately softball-sized patched area on the wall. Interview on 8/23/18 client #2 stated: - "I hit the walls" - "I had to pay for the wall to get fixed." - "They patched them up last month, but they didn't get the money because I didn't have enough." Interview on 8/21/18 the Facility Qualified Professional (QP) stated: - Client #2 has a behavior of hitting the walls when he is upset. Interview on 8/23/18 the Facility Deputy Director stated: - We have asked client #2 to reimburse for the property damage and we have used the Facility Quarterly Report to show the amount of the damages once they were taken from his account. - We have provided the quarterly form to the client and the guardian at the end of every quarter. - Client #2 will come and try to pay for the	V 543		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL026-299	A. BUILDING: _____ B. WING _____	R 08/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANBERRY PLACE	1909 STANBERRY PLACE FAYETTEVILLE, NC 28301

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 543	Continued From page 11 damages on his own. Review on 8/23/18 of the Facility's Client Personal Funds Quarterly Report form revealed: - "...The purpose of this reporting is threefold: first, to meet standard 10A NCAC 27F .0105 (c) and (d); second to inform client of their personal fund activities, and for tracking purposes. The quarterly reports will be completed within 10 days after the end of each federal fiscal quarter...Clients are given a copy of the report evidenced by signature or initial..." Interview on 8/23/18 the Facility QP stated: - She was not aware rule regarding the use of funds for damages by a client. - The facility would follow-up on the issue and corrections needed.	V 543		
V 736	27G .0303(c) Facility and Grounds Maintenance 10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS (c) Each facility and its grounds shall be maintained in a safe, clean, attractive and orderly manner and shall be kept free from offensive odor. This Rule is not met as evidenced by: Based on observation and interview, the facility was not maintained in a safe, clean, attractive and orderly manner free of offensive odor. The findings are: Observations on 8/21/18 between 10:30am and 11:30 am revealed: -Family room:	V 736		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL026-299	A. BUILDING: _____ B. WING _____	R 08/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANBERRY PLACE	1909 STANBERRY PLACE FAYETTEVILLE, NC 28301

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 736	Continued From page 12 -Chirping could be heard from smoke detector on entry to home. Battery compartment of smoke detector on living room ceiling had been opened and no batteries were in place. -Pungent odor noted on entrance to home; smell consistent with that of urine. -Tears and stains in carpet. -Surface of coffee table worn away. -Legs of coffee table slanted to one side -Surface of door facings leading into kitchen stained and worn away. -Kitchen: -Flooring torn at refrigerator. -Three plastic bread bags tied in a knot on top of refrigerator with 6-8 slices of bread in each bag. -Baseboards coated with dust and other unknown particles within kitchen area. -Hall bathroom: Pungent odor consistent with the odor of urine noted. Unfinished wood molding mounted under mirror. Dark brown substance adhered to toilet bowl rim. Rusted floor vent. Dirt and dust build up on surfaces of baseboards and corners of the floor. Client #1's Bedroom: -Bedroom had pink curtains from previous discharged client. -Closet contained 5 plastic bags with cloth materials stacked and no hanging clothes. -Wall in his bedroom had a spot on the wall approxiamately the size of a dinner plate. -Dresser was missing one to two handles for the drawers. -Client #2's Bedroom: -The bedroom walls had approximately 3 - 4 total softball-sized unpainted patched areas within the room. -Bedroom door had an approximate 1 foot square wooden panel patched onto top left section of the door.	V 736		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL026-299	A. BUILDING: _____ B. WING _____	R 08/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANBERRY PLACE	**1909 STANBERRY PLACE FAYETTEVILLE, NC 28301**

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 736	Continued From page 13 -Hallway wall leading to client #2's room had an unpainted approximately softball-sized patched area on the wall. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 736		