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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED			
AND PLAN OF CORRECTION IDENTIFICATION NOWIBER.		A. BUILDING:		COWIFLETED				
		MIII 00 4 000	B. WING		R			
MHL084-089					08/31	1/2018		
NAME OF PR	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
MOSS LAN	NE II		ISS LANE IDON, NC 2812	7				
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)		
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	COMPLETE DATE		
V 000	INITIAL COMMENTS		V 000					
	An annual and follow on 8/31/18. Deficience	up survey was completed ies were cited.						
	category: 10A NCAC	d for the following service 27G .5600C Supervised Developmental Disabilities.						
V 290	90 27G .5602 Supervised Living - Staff		V 290					
	of this Rule shall be denable staff to responneeds. (b) A minimum of one present at all times we premises, except whe habilitation plan docucapable of remaining without supervision. as needed but not less the client continues to the home or commun specified periods of ti (c) Staff shall be presentled or adolescent client or adolescent clients present for clients present. How present during sleeping emergency back-up put the governing body; (2) children or addevelopmental disabilitation of the clients present disabilitation and developmental disabilitation of the clients present disabilitation and developmental disabilitation of the clients present disabilitation and developmental disabilitation present disabilitation of the clients present disabilitation of the clients present disabilitation of the clients present disabilitation and developmental disabilitation of the clients present disabilitation plan documentation of the clients present disabilitation plan documentation plan disabilitation plan documentation plan disabilitation plan documentation plan disabilitation plan documentation plan disabilitation plan disabilitation plan documentation plan disabilitation plan disabilitation plan documentation plan disabilitation plan disabilitat	above the minimum Paragraphs (b), (c) and (d) letermined by the facility to letermined be letermined by the letermined by letermin						

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

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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	
			7.11.201.22.11.101			R
MHL084-089		B. WING		08	B/31/2018	
NAME OF D	ROVIDER OR SUPPLIER	CTDEET /	ADDRESS, CITY, STATE	ZID CODE	,	
NAME OF P	ROVIDER OR SUPPLIER		IOSS LANE	, ZIP CODE		
MOSS LA	NE II		ONDON, NC 28127			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	COMPLETE DATE
V 290	Continued From page	e 1	V 290			
	need be present duri specified by the eme determined by the go (d) In facilities which diagnosis is substand (1) at least one duty shall be trained withdrawal symptoms secondary complicati drug addiction; and	rgency back-up procedures overning body. serve clients whose primary ce abuse dependency: e staff member who is on in alcohol and other drug ons to alcohol and other s of a certified substance ll be available on an				
	facility failed to ensur habilitation plan docu capable of remaining without supervision a The findings are: Review on 8/31/18 of -diagnoses of Autism Disorder, Bipolar Dis Disorder, Borderline Attention Deficit Hypo- admission date of 17 -treatment plan dated of express frustration learn medications, pr	riew and interviews, the re the client's treatment or remented that the client was in the home or community ffecting 1 of 3 clients (#3). If client #3's record revealed: , Reactive Attachment order, Post Traumatic Stress Personality Disorder and reactivity Disorder; 1/10/17; 1/1/1/18 documented goals s daily in appropriate ways, repare weekly menus, use on the phone and learn fills; If an assessment for				

Division of Health Service Regulation

STATE FORM 6899 E2M611 If continuation sheet 2 of 5

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
	MHL084-089 B. WING		R 08/31/2018				
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
MOSS LAI	MOSS LANE II 42414 MOSS LANE NEW LONDON, NC 28127						
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE	
V 290	time in the treatment Interview on 8/31/18 -has a boyfriend; -she is her own guard -sees her boyfriend e -stays about 2 hours -staff takes her and d -always been like tha Interview on 8/31/18 -take client #3 to her weekends; -client #3 stays about -drops client #3 off ar -always been like this Interview on 8/31/18 Qualified Professiona -does not have unsup treatment plan; -client #3 always visit -will do unsupervised treatment plan.	with client #3 revealed: dian; very weekend; at her boyfriend's house; rops her off; t. with staff #1 revealed: boyfriend's house on the two hours; nd picks her up later; direvealed: bervised time in client #3's led her boyfriend; time assessment and put in ditutes a re-cited deficiency	V 290				
V 738	27G .0303(d) Pest Co 10A NCAC 27G .0300 EXTERIOR REQUIR (d) Buildings shall be rodents.	3 LOCATION AND	V 738				

Division of Health Service Regulation

STATE FORM 6899 E2M611 If continuation sheet 3 of 5

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BUILDING		R	
MHL084-089		B. WING	B. WING			
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STAT	E, ZIP CODE		
MOSS LA	NE II	42414 MO	SS LANE			
WOOD LA	NE II	NEW LON	IDON, NC 28127	•		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
V 738	Continued From page	2 3	V 738			
	This Rule is not met as evidenced by: Based on observations and interviews, the facility was not kept free from insects and rodents. The findings are: Observation on 8/31/18 at 345pm revealed: -small black pieces of what appeared to be rodent droppings in the left corner of client #3's bathroom behind storage containers; -cinnamon spice around the outside bottom of client #3's bathtub; -dead ants near the bottom of the bathroom wall. Interview on 8/31/18 with client #3 revealed: -had ants in her bedroom; -saw some ants yesterday; -big ant hills in yard; -staff have sprayed but ants came back; -exterminator came one time; -saw a mouse the nigh before; -staff has seen the mouse.					
	-has seen one mouse	r clothing basket she had on				
	-saw ants last Friday; -gone by Monday; -staff sprayed; -not seen a mouse;	with client #1 revealed: g they saw the mouse.				
	-have seen small blad	with staff #1 revealed: ck ants in the facility; but have heard other staff				

Division of Health Service Regulation

say they have seen the mouse.

STATE FORM 6899 E2M611 If continuation sheet 4 of 5

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Division of Health Service Regulation

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			B. WING			R	
		MHL084-089	B: Wilto		08	/31/2018	
NAME OF P	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE						
MOSS LANE II NEW LONDON, NC 28127							
(X4) ID	SUMMARY ST	FATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF (CORRECTION	(X5)	
PREFIX TAG	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ON SHOULD BE HE APPROPRIATE	COMPLETE DATE	

Division of Health Service Regulation

STATE FORM 6899 E2M611 If continuation sheet 5 of 5