Division of Health Service Regulation

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,	X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL038-024	B. WING		08/2	7/2018	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
THE PASSAGE 532 MOOSE BRANCH ROAD							
	OLUMBA DV OTA		VILLE, 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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE	
V 000	INITIAL COMMENT	TS .	V 000				
	An annual survey w 2018. A deficiency	as completed on August 27, was cited.					
		sed for the following service C 27G .5600A Supervised h Mental Illness.					
V 290	27G .5602 Supervis	sed Living - Staff	V 290				
	numbers specified in of this Rule shall be enable staff to responseds. (b) A minimum of compresent at all times premises, except whabilitation plan doccapable of remaining without supervision as needed but not let the client continues.	os STAFF is above the minimum in Paragraphs (b), (c) and (d) is determined by the facility to cond to individualized client one staff member shall be when any adult client is on the hen 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					
	specified periods of (c) Staff shall be pr following client-staff child or adolescent (1) children o abuse disorders sha of one staff present	time. resent in a facility in the ratios when more than one					
	present during slee emergency back-up the governing body (2) children o developmental disa one staff present fo	ping hours if specified by the procedures determined by					

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

(X6) DATE TITLE

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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 NOMBER.	A. BUILDING:		OOWII	LLILD
MHL038-024		MHL038-024	B. WING		08/27/2018	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
THE PAS	SSAGE		SE BRANCH VILLE, 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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
V 290	more clients preser need be present du specified by the em determined by the (d) In facilities which diagnosis is substa (1) at least of duty shall be trained withdrawal symptom secondary complication; and (2) the service	at. However, only one staff uring sleeping hours if pergency back-up procedures governing body. The serve clients whose primary nee abuse dependency: The staff member who is one d in alcohol and other drug ms and symptoms of ations to alcohol and other drug less of a certified substance and be available on an	V 290			
	failed to ensure that times when any add. The findings are: Observation at 9:00 the facility for the arburd and the facility for the arburd and the facility was looked as a second and the facility. The two factions were within walking. Interview on 8/27/1 - One client did not would refuse to gor - There were times a sister facility would the facility because leave.	on and interviews the facility tone staff was present at all ult client is on the premises. OAM on 8/27/18 when entering natural survey revealed: ee current clients and a cated next door to a sister cilities shared a driveway and distance to each other. 8 with Staff #1 revealed: like to leave the facility and				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: (X3)			(X3) DATE SURVEY COMPLETED		
		MHL038-024	B. WING		08/2	7/2018		
THE PASSAGE 532 MOOSE				DRESS, CITY, STATE, ZIP CODE SE BRANCH ROAD VILLE, NC 28771				
(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 SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE		
V 290	facility for "Meaning one on one service: those clients into th activities. She provided week for two hours with the clients from member of the sisted would be on site at supervision. Interview on 8/27/13 revealed: -The two facilities so ther with supervision. There were occasi two clients out and to go to the house into go then the staff would come to the following to the linterview on 8/27/13 revealed: -The "Meaningful D by a staff member to where the client lived the felt that the bernext door to each of interchange staff will the acknowledged beneficial to staff are	Iful Days". This was similar to so in which she would take the community for different wided this service 7 days a per day. When she worked in the sister facility, the staff ter facility and those clients ther facility to provide. Be with the House Manager the idea by side would assist each on. Ons when one staff would take take the client who didn't want the idea to interest from the idea of facility and stay. Be with the Operations Manager ay" service had to be provided that did not operate the facility and according to the LME-MCO. Inefit of having the facilities ther was that they could	V 290					

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