Division of Health Service Regulation

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL038-024	B. WING		08/27/2018	
NAME OF I	PROVIDER OR SUPPLIER	STDEET AD	DDESS CITY (STATE, ZIP CODE		
NAIVIE OF I	PROVIDER OR SUPPLIER		SE BRANCH			
THE PAS	SAGE		SULLE, NC 2			
0/10 ID	CHIMMA DV CTA		· ·	PROVIDER'S PLAN OF CORRECTI	ON OVE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	LD BE COMPLETE	
V 000	INITIAL COMMENTS		V 000			
	An annual survey w 2018. A deficiency	ras completed on August 27, was cited.		RECEIVED By DHSR - Mental Health Lic. & Cert. Section at 8:41 am, S	pp 20, 2018	
		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 responeeds. (b) A minimum of copresent at all times premises, except whabilitation plan docapable of remaining without supervision as needed but not lithe client continues the home or common specified periods of (c) Staff shall be profollowing client-staff child or adolescent (1) children of abuse disorders should one staff present clients present. However, the governing slee emergency back-up the governing body (2) children of developmental disa	is above the minimum in Paragraphs (b), (c) and (d) is determined by the facility to ond 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 itime. It is a facility in the factor of the fac				
		r every one to three clients off present for every four or				

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 FLAN OF CONNECTION			A. BUILDING:		OOMI LETED		
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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE COMPLETE		
V 290	Continued From page 1 more clients present. However, only one staff need be present during sleeping hours if specified by the emergency back-up procedures determined by the governing body. (d) In facilities which serve clients whose primary diagnosis is substance abuse dependency: (1) at least one staff member who is on duty shall be trained in alcohol and other drug withdrawal symptoms and symptoms of secondary complications to alcohol and other drug addiction; and (2) the services of a certified substance abuse counselor shall be available on an as-needed basis for each client.		V 290				
	failed to ensure that times when any add The findings are: Observation at 9:00 the facility for the arbital and three capacity of 6. The facility was loof facility. The two facility. The two facility were within walking Interview on 8/27/1. One client did not would refuse to go	on and interviews the facility tone staff was present at all ult client is on the premises. OAM on 8/27/18 when entering innual 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		By 10/1/18 ACS will provide additional staneeded to provide a meaningful day to rereceiving Long Term Community Support	sidents		
	sister facility would the facility because leave.	bring their clients and stay in Client #1 did not want to					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(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	PROVIDER OR SUPPLIER	532 MOOS	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 ide by side would assist each on. Ons when one staff would take take the client who didn't want the identification. If the client refused and clients from next door 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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