| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | ` ' | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | | | |
|---|--|---|---------------------|--|------|--------------------------|--|--|
| | | B. WING | | R | | | | |
| | | MHL096-117 | B. WING | - | 09/2 | 5/2018 | | |
| NAME OF | NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE | | | | | | | |
| COUNTE | COUNTRY PINES #1 2307 NORTH BESTON ROAD | | | | | | | |
| | | | GE, NC 285 | | | | | |
| (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 | S | V 000 | | | | | |
| | completed on Septe complaints were un #NC00136271 and were cited. This facility is licens category: 10A NCA | nt and follow up survey was ember 25, 2018. The substantiated (intake #NC00138766). Deficiencies sed for the following service &C 27G .5600C, Supervised | | | | | | |
| V 112 | | h Developmental Disabilities. | V 112 | | | | | |
| V 112 | 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. | | V 112 | | | | | |

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

(X6) DATE TITLE

| STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED | |
|---|---|--|---|---|-------------------------------|--|
| MHL096-117 | | B. WING | | R 09/25/2018 | | |
| NAME OF | PROVIDER OR SUPPLIER | | , , | STATE, ZIP CODE | | |
| COUNTR | RY PINES #1 | | RTH BESTON GE, NC 285 | | | |
| (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) | | |
| V 112 | Continued From pa | ge 1 | V 112 | | | |
| | facility failed to developed based on assessment clients (#4). The firm Review on 3/5/18 at record revealed: - 41 year old femaled 4/29/03 Diagnoses included Intellectual/Developed Control Disorder, At Hypothyroidism, Hy - "Individual Support 5/1/17 from the Local included "What Oth Support Me Be have decreased. [Outlieting schedule to accidents" - "Individual Suppowith no strategies to needs or toileting properties on Professional/Chief I was responsible for and strategies for coneeds. There were client #4's one hour He understood the | views and interviews the elop and implement strategies ent for one of three audited ndings are: Ind 9/25/18 of client #4's e admitted to the facility ed Severe mental Disability, Impulse trial Septum Deficit, pertension. It Plan" with start date of eal Management Entity ers Need to Know to Best ehaviors Toileting skills Client #4] is on a one hour or reduce incidents of eat Plan" implemented 5/1/17 to address client #4's toileting | | | | |

Division of Health Service Regulation STATE FORM

6899 231M11 If continuation sheet 2 of 5

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | | | (X3) DATE SURVEY COMPLETED | |
|--------------------------|---|---|----------------------------|---|---------|-------------------------------|--|
| AND TERM OF CONNECTION | | A. BUILDING: | | | R | | |
| | | MHL096-117 | B. WING | | | ≺ 25/2018 | |
| NAME OF I | PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, S | STATE, ZIP CODE | | | |
| COUNTR | RY PINES #1 | | RTH BESTON GE, NC 285 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY) | OULD BE | (X5) COMPLETE DATE | |
| V 736 | Continued From pa | ge 2 | V 736 | | | | |
| V 736 | 27G .0303(c) Facili | ty and Grounds Maintenance | V 736 | | | | |
| | EXTERIOR REQUI (c) Each facility and maintained in a safe | 03 LOCATION AND REMENTS I its grounds shall be e, clean, attractive and orderly e kept free from offensive | | | | | |
| | was not maintained | et as evidenced by: on and interviews the facility in a safe, clean, orderly ffensive odors. The findings | | | | | |
| | pm on 9/25/18 reversely was perfront room. - The 5 light overhed was missing 2 shade. - The carpet in the from the wall and we floor and presented. - A brown stain on the from the paint was performed by the floor and presented. - A strong moldy odd storage closet in the floor and presented. - The paint was performed by the floor and we wide entry hallway. - A television and we wide entry hallway. - Round air vents in bedroom were rusty looking substance of the smoke detected dusty. - Matter that appears. | eling away at the seams in the rad fixture in the front room des and 1 light bulb. Front room was separated as worn and wrinkled on the a tripping hazard. The ceiling in the front room. or was noted inside the | | | | | |

Division of Health Service Regulation STATE FORM

| AND PLAN OF CORRECTION | | | | COMPLE | DATE SURVEY COMPLETED | |
|---|---|----------------|---|------------|--------------------------|--|
| | | 7 % BOILDING. | BOILDING. | | R | |
| MHL096-117 | | B. WING | | 09/25/2018 | | |
| NAME OF PROVIDER OR SUPPLIER | STREET ADI | DRESS, CITY, S | STATE, ZIP CODE | | | |
| COUNTRY PINES #1 | 2307 NOR | TH BESTON | ROAD | | | |
| | LA GRAN | GE, NC 285 | 51 | | | |
| PREFIX (EACH DEFICIENCY M | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | (EACH CORRECTIVE ACTION SHOULD BE COMPL | | (X5) COMPLETE DATE | |
| V 736 Continued From page | e 3 | V 736 | | | | |
| bathroom. - Client #1's bathroom. - The ceiling in client: be sagging over the to Brown stains on the bathroom. - A row of floor tiles we the bathtub. - The exhaust fan was powdery looking subsection - Client #1's shower or rusty. - Client #1's bathtub how | n had a strong moldy odor. #1's bathroom appeared to oilet. ceiling of client #1's vere missing at the face of s loud, and rusty with black stance on the outer surface. curtain rod was extremely had greenish gray staining. missing from client #3's h ceiling was dusty around window. curtain liner had heavy d to be dead insects were t fixtures in client #3's h ceiling over client #3's h client #3's bathroom was | V 736 | | | | |

Division of Health Service Regulation

STATE FORM 6899 231M11 If continuation sheet 4 of 5

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/ AND PLAN OF CORRECTION IDENTIFICATION NUMBER | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED | |
|---|--|--|--|-------------------------------|--------------------------|
| | | A. BUILDING. | | R | |
| 1 | MHL096-117 | B. WING | | | 5/2018 |
| NAME OF PROVIDER OR SUPPLIER | STREET ADI | DRESS, CITY, S | STATE, ZIP CODE | | |
| COUNTRY PINES #1 | | TH BESTON GE, NC 285 | | | |
| (X4) ID SUMMARY STATEMENT | | ID | PROVIDER'S PLAN OF CORRECT | ION | (YE) |
| (X4) ID SUMMARY STATEMENT PREFIX (EACH DEFICIENCY MUST E REGULATORY OR LSC IDEN | BE PRECEDED BY FULL | PREFIX TAG | (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRODEFICIENCY) | LD BE | (X5) COMPLETE DATE |
| V 736 Continued From page 4 | | V 736 | | | |
| was worn Client #4 and #6's shown heavily stained with milder. The round exhaust vent rusty and had black stains The drain grate was mis #6's bathtub Brown stains to client #5's bi-fold its track The carpet in the den and kitchen was heavily stained The kitchen ceiling was stusty A partially smoked cigard kitchen counter next to the The finish on the molding kitchen door was dirty and The toaster oven was extended through the plass door to be opaqued. Flies were noted through the plass of | over the bathtub was son the outside surface. sing from client #4 and it's bedroom ceiling. closet doors was out of ea adjacent to the ed and worn. stained yellow and was ette was seen on the e back door. g around the back d stained. Attremely grimy causing ue. nout the facility. 18 the Qualified tive Officer stated the eptic tank issues; the uped out twice. He | V 736 | | | |

Division of Health Service Regulation STATE FORM