		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:			PLETED	
		MHL092-895	B. WING			R 11/15/2018	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE			
JACE HE	ALTHCARE		TERS DRIVE				
		RALEIG	H, NC 27610			1	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLETI DATE	
V 000	INITIAL COMMENT	ſS	V 000				
	An annual and follo on 11/15/18. Deficie	w up survey was completed encies were cited.					
		sed for the following services: DC Supervised Living for omental Disabilities.					
V 289	27G .5601 Supervis	sed Living - Scope	V 289				
	provides residential home environment these services is th rehabilitation of indi illness, a developm or a substance abu supervision when ir (b) A supervised liv the facility serves e (1) one or mo (2) two or mo (3) two or mo (3) "C" design serves adults whos	ving facility shall be licensed if ither: ore minor clients; or ore adult clients. ents shall not reside in the d living facility shall be specific population as nation means a facility which e primary diagnosis is mental o have other diagnoses; nation means a facility which se primary diagnosis is a bility but may also have other nation means a facility which e primary diagnosis is a					
	diagnoses;	bility but may also have other nation means a facility which					

	of Health Service Re T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	. ,	CONSTRUCTION		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COM	PLETED
		MHL092-895	B. WING		R 11/15/2018	
NAME OF F	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
	ALTHCARE		TERS DRIVE			
	ALINGARE	RALEIGI	H, NC 27610			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 289	Continued From pa	ige 1	V 289			
	substance abuse d other diagnoses; (5) "E" design serves adults whos substance abuse d other diagnoses; or (6) "F" design private residence, w three adult clients w mental illness but n disabilities, or three clients whose prima developmental disa other disabilities wh family provides the exempt from the fo .0201 (a)(1),(2),(3), (A),(B),(E),(F),(G),((18) and (b); 10A NCAC 27G .0208 (b),(e); non-prescription me (1)(A),(D),(E);(f);(g) (b)(2),(d)(4). This f	hation means a facility in a which serves no more than whose primary diagnoses is nay also have other e adult clients or three minor ary diagnoses is abilities but may also have no live with a family and the service. This facility shall be llowing rules: 10A NCAC 27G (4),(5)(A)&(B); (6); (7) H); (8); (11); (13); (15); (16); CAC 27G .0202(a),(d),(g)(1) .0203; 10A NCAC 27G .0205 27G .0207 (b),(c); 10A NCAC 10A NCAC 27G .0209[(c)(1) - edications only] (d)(2),(4); (e)); and 10A NCAC 27G .0304 facility shall also be known as ving or assisted family living				
	Based on record re failed to operate un	view and interview the facility ider the scope for which it is clients (#3 & #4). The findings				
		of client #3's record revealed: facility on 12/5/16				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
					R	
		MHL092-895	B. WING		11/	15/2018
AME OF I	PROVIDER OR SUPPLIER		DRESS, CITY, ST	TATE, ZIP CODE		
ACE HE	EALTHCARE		FERS DRIVE I, NC 27610			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLE DATE
V 289	 diagnoses of S use no documentat Review on 11/9/18 admitted to the diagnoses of S and Asthma no documentat During interview on Professional report he was not part the Licensee en 	chizophrenia and Cannabis ion of DD diagnosis of client #4's record revealed: facility on 9/26/12 chizophrenia; Hypertension ion of DD diagnosis 11/15/18 the Qualified	V 289			
V 290	numbers specified of this Rule shall be enable staff to resp needs. (b) A minimum of of present at all times premises, except w habilitation plan doo capable of remainin without supervision as needed but not I the client continues the home or comm specified periods of (c) Staff shall be p following client-staff child or adolescent	502 STAFF bes above the minimum in Paragraphs (b), (c) and (d) e 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 ng 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 time. resent in a facility in the f ratios when more than one	V 290			

UIVISION	of Health Service Re	gulation	T			
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		MHL092-895	B. WING		R 11/15	
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE	•	
	EALTHCARE		TERS DRIVE			
			I, NC 27610			-
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE	(X5) COMPLETE DATE
V 290	Continued From pa	ge 3	V 290			
	of one staff present clients present. Ho present during sleep emergency back-up the governing body; (2) children o developmental disa one staff present fo present and two sta more clients present need be present du specified by the em determined by the g (d) In facilities which diagnosis is substant (1) at least or duty shall be trained withdrawal symptom secondary complicat drug addiction; and (2) the service	r adolescents with bilities shall be served with r every one to three clients iff present for every four or at. However, only one staff ring sleeping hours if ergency back-up procedures governing body. th serve clients whose primary nce abuse dependency: the staff member who is on d in alcohol and other drug ns and symptoms of ations to alcohol and other the es of a certified substance hall be available on an				
	failed to ensure one treatment plan docu	et as evidenced by: view and interview the facility e of three audited clients (#1) umented he was capable of mmunity without supervision.				
	 admitted to the diagnosis of Sc Hypothyroidism and 	of client #1's record revealed: facility on 8/21/15 hizoaffective Disorder; Autism n dated 3/24/18 with no				

C

STATEMEN	of Health Service Re NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		MHL092-895	B. WING		– R 11/15/2018	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
JACE HE	EALTHCARE		TERS DRIVE H, NC 27610			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
V 290	Continued From pa	ge 4	V 290			
	documentation of u	nsupervised time				
	 he has been at he currently has community 2 hours on Mor Thursday; 6 hours of Saturday and Sund During interview on Professional reports client #1 had up community the unsupervise contract from the tr #1's guardian appropriation of the second second	nsupervised time in the ed time was a separate eatment plan in which client				
V 500	10A NCAC 27D .01 RESTRICTIONS AI (a) The governing assures the implem G.S. 122C-65, and (b) The governing implement policy to (1) all instance abuse, neglect or e reported to the Cou Services as specifie G.S. 7A, Article 44; (2) procedure instituted in accorde practice when a me	body shall develop and assure that: ces of alleged or suspected xploitation of clients are inty Department of Social ed in G.S. 108A, Article 6 or	V 500			

Division	of Health Service Re	aulation			FORM	APPROVED
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	COMF	E SURVEY PLETED
		MHL092-895	B. WING			R I 5/2018
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE		
JACE HE	EALTHCARE		TERS DRIVE I, NC 27610			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORREC	TION	(X5)
PREFIX TAG		MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)		COMPLETE DATE
V 500	Continued From pa	ge 5	V 500			
	neuroleptic medicat (c) In addition to th 10A NCAC 27E .01 each facility shall de that identifies: (1) any restrice prohibited from use (2) in a 24-ho under which staff ar the rights of a client (d) If the governing restrictive interventi the restrictions of cl 122C-62(b) and (d) identify: (1) the permit allowed restrictions (2) the individe the client; and (3) the due per involuntary client wh restrictive interventi (e) If restrictive interventi (e) If restrictive interventi (e) If restrictive interventi (f) the design has been trained ar competence to use provide written auth restrictive interventi renewed for up to a accordance with the NCAC 27E .0104(e (2) the design responsible for revie interventions; and	ose procedures prohibited in 02(1), the governing body of evelop and implement policy ctive intervention that is within the facility; and our facility, the circumstances re prohibited from restricting body allows the use of ons or if, in a 24-hour facility, ient rights specified in G.S. are allowed, the policy shall tted restrictive interventions or lual responsible for informing rocess procedures for an no refuses the use of ons. erventions are allowed for use e governing body shall nent policy that assures bchapter 27E, Section .0100, nation of an individual, who nd who has demonstrated restrictive interventions, to orization for the use of ons when the original order is total of 24 hours in e time limits specified in 10A				
Division of H	ealth Service Regulation					

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED
	0. 00		A. BUILDING:			
		MHL092-895	B. WING			R 15/2018
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
ACE HE	EALTHCARE		TERS DRIVE H, NC 27610			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
V 500	Continued From pa	ge 6	V 500			
	appeal for the resol	lishment of a process for lution of any disagreement se of a restrictive intervention.				
	interview, the gover client rights were no	ion, record review and rning body failed to ensure ot restricted as specified in affected four of four clients				
	revealed "A written the client's record to reason for the restr reasonable and rela habilitation needs. A period not to excee each restriction sha qualified profession days, at which time	of General Statue 122C-62 statement shall be placed in hat indicates the detailed iction. The restriction shall be ated to the client's treatment o A restriction is effective for a d 30 days. An evaluation of all be conducted by the hal (QP) at least every seven the restriction may be iluation of a restriction shall be client's records."				
	 there was a loc refrigerator the freezer port 	9/18 at 12:32pm revealed: k on the bottom portion of the tion of the refrigerator had two lock could attach to however,				
	 some of the clic refrigerator during t she was inform attempt to cook dur this has not hap 	ed a client would get up an				

If continuation sheet 7 of 11

	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION		
ND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COM	PLETED
		MHL092-895	B. WING		R 11/15/2018	
IAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
	ALTHCARE	1921 WA	TERS DRIVE			
		RALEIGH	I, NC 27610			1
(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 (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
V 500	Continued From pa	age 7	V 500			
	locked from 10pm	(including freezer portion) was - 6am as aware the refrigerator was				
	 the refrigerator able to go in and or needed to staff will give his opened the refriger 	11/14/18 client #1 reported: was locked, however he was ut of the refrigerator when he im the key, however staff rator for the other clients od was being stolen out of the				
	- other clients we the refrigerator	n 11/14/18 client #2 reported: ere allowed to go in and out of ock it for him to go in the at				
	 when he arrive rehabilitation in the locked he was informe refrigerator 	n 11/14/18 client #3 reported: d from the psychosocial afternoon the refrigerator was ed clients stole food from the ock the refrigerator if he				
	reported: - she was aware during the night - clients would g items during the nig - a client one tim sick the next morni	e drank all the milk and was				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		MHL092-895	B. WING		R 11/15/2018	
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
ACE HE	EALTHCARE		TERS DRIVE H, NC 27610			
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	THE APPROPRIATE DATE	
V 500	Continued From pa	ge 8	V 500			
	out of the refrigerat	or				
V 738	 he was aware the night a client was turn to cook at nightfor refrigerator it was decided the client's final snather turned on the stove 27G .0303(d) Pest 10A NCAC 27G .033 	II the clients that stole food or Control 603 LOCATION AND	V 738			
	This Rule is not me Based on observati	et as evidenced by: on and interviews the facility				
	failed to ensure the insects. The finding	facility was kept free of s are:				
	 at 12:32 a baby of the refrigerator 	9/18 revealed the following: / roach crawled along the side aby roach crawled on the sink athroom				
	- she has been s roaches	11/9/18 staff #1 reported: beeing a couple of baby or supposed to come to the				

	IT OF DEFICIENCIES	Qulation (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
			A. BUILDING:			R
		MHL092-895	B. WING	B. WING		15/2018
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
JACE HE	EALTHCARE		TERS DRIVE H, NC 27610			
(X4) ID			ID	PROVIDER'S PLAN OF C		(X5) COMPLETE
PREFIX TAG		MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	IE APPROPRIATE	DATE
V 738	Continued From pa	ge 9	V 738			
	facility on 11/14/18					
	During interview on	11/13/18 the Licensee				
	reported:	r was scheduled to come to				
	the facility tomorrow					
V 752	27G .0304(b)(4) Ho	t Water Temperatures	V 752			
	10A NCAC 27G .03	10A NCAC 27G .0304 FACILITY DESIGN AND				
	EQUIPMENT	allity about the decision of				
		cility shall be designed, uipped in a manner that				
		al safety of clients, staff and				
	visitors. (4) In areas o	f the facility where clients are				
		er, the temperature of the				
	degrees Fahrenheit	tained between 100-116 				
	This Rule is not me	et as evidenced by:				
		on and interview the facility				
		facility's water temperatures tween 100-116 degrees. The				
	findings are:	-				
		vation on 11/9/18 of the				
	facilities water temp following:	peratures revealed the				
		kitchen's sink temperature				
	was 120 - at 12:42pm the	downstairs bathroom sink				
	was 120					
	- at 12:45pm the sink was 120	upstairs hallway bathroom				
		11/9/18 staff #1 reported:				
	 she does not ch 	neck water temperatures at				

STATEMEN	of Health Service Re IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
			A. BUILDING:			
		MHL092-895	B. WING	1		R 15/2018
NAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST	ATE, ZIP CODE		
JACE HE	EALTHCARE		TERS DRIVE H, NC 27610			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
V 752	water temperatures During interview on complaints of water During interview on reported: - staff contacted water temperatures	e not complained about the s being too hot 11/14/18 the clients had no r temperatures being too high 11/13/18 the Licensee her after the survey about the s e there tomorrow (11/14/18) to		DEFICIENC	ΥΥ) 	
ision of H	ealth Service Regulation					