

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>mhl-059036</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>10/25/2018</b>
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NAME OF PROVIDER OR SUPPLIER  
**NEBO SUPERVISED LIVING**

STREET ADDRESS, CITY, STATE, ZIP CODE  
**2121 OLD HWY #10 EAST  
NEBO, NC 28761**

(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)	(X5) COMPLETE DATE
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V 000 **INITIAL COMMENTS**

An annual and follow up survey was completed on October 25, 2018. Deficiencies were cited.

This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities.

V 000

V 114 **27G .0207 Emergency Plans and Supplies**

10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES

(a) A written fire plan for each facility and area-wide disaster plan shall be developed and shall be approved by the appropriate local authority.

(b) The plan shall be made available to all staff and evacuation procedures and routes shall be posted in the facility.

(c) Fire and disaster drills in a 24-hour facility shall be held at least quarterly and shall be repeated for each shift. Drills shall be conducted under conditions that simulate fire emergencies.

(d) Each facility shall have basic first aid supplies accessible for use.

V 114

This Rule is not met as evidenced by:  
Based on record review and interview the facility failed to conduct fire and disaster drills quarterly on each shift and failed to ensure evacuation routes were posted. The findings are:


Observation on 10/25/18 at 10:55am during the facility tour revealed that no evacuation routes were posted in the facility.

Review on 10/25/18 of the fire and disaster drills

DHSR - Mental Health  
DEC 03 2018  
Lic. & Cert. Section

To ensure that fire drills and disaster drills are both brought back into compliance and stay in compliance, North Carolina Outreach Group Homes, LLC has devised a schedule for conducting regularly scheduled fire and disaster drills. The schedule will be modified yearly so that residents do not realize that the drills are scheduled, but employees will be provided with the dates and times that they are to conduct the appropriate quarterly drills. The schedule was created in a spreadsheet program that allows for formulaic progression of dates, and these will be used to ensure timely drills that appear random to individuals within our care.

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

X 

TITLE

owner / administrator

(X6) DATE

11/21/2018

Division of Health Service Regulation

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V 114	Continued From page 1 for the facility revealed: -No second shift fire drill for the first quarter of 2018. -No first shift disaster drill for the second quarter of 2018.  Interview on 10/25/18 with the owner revealed: -The facility had 2 shifts and staff should be aware of the time frames for all drills. -She would now implement a schedule for drills to ensure they were all completed. -She did not know that evacuation routes were required to be posted for view in the facility.	V 114	To bring the facility within compliance regarding evacuation routes, floor plans have been drawn up as well as saved and evacuation routes have been posted in each area of the facility.	
V 291	27G .5603 Supervised Living - Operations  10A NCAC 27G .5603 OPERATIONS (a) Capacity. A facility shall serve no more than six clients when the clients have mental illness or developmental disabilities. Any facility licensed on June 15, 2001, and providing services to more than six clients at that time, may continue to provide services at no more than the facility's licensed capacity. (b) Service Coordination. Coordination shall be maintained between the facility operator and the qualified professionals who are responsible for treatment/habilitation or case management. (c) Participation of the Family or Legally Responsible Person. Each client shall be provided the opportunity to maintain an ongoing relationship with her or his family through such means as visits to the facility and visits outside the facility. Reports shall be submitted at least annually to the parent of a minor resident, or the legally responsible person of an adult resident. Reports may be in writing or take the form of a conference and shall focus on the client's progress toward meeting individual goals.	V 291		

Division of Health Service Regulation

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NAME OF PROVIDER OR SUPPLIER  <b>NEBO SUPERVISED LIVING</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2121 OLD HWY #10 EAST NEBO, NC 28761</b>
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V 291	<p>Continued From page 2</p> <p>(d) Program Activities. Each client shall have activity opportunities based on her/his choices, needs and the treatment/habilitation plan. Activities shall be designed to foster community inclusion. Choices may be limited when the court or legal system is involved or when health or safety issues become a primary concern.</p> <p>This Rule is not met as evidenced by: Based on observation and interview the facility failed to maintain a capacity of no more than six clients with mental illness or developmental disabilities. The findings are:</p> <p>Observation on 10/15/18 at 10:30am revealed 7 clients being served on that date. Additionally, 5 clients were also on site who were residents of the sister facility. Three staff were present.</p> <p>Review on 10/15/18 of the license for the facility revealed that on October 1, 2018 the facility capacity had been reduced from 9 to 6.</p> <p>Interview on 10/15/18 with the Owner revealed: -When the facility requested the reduction in capacity he had been told the process would take 2-3 weeks. He stated that it took one week. He stated that he was quickly trying to find alternative placements for their clients. They were unable to move all clients before the license changed. -One last client was moving on 10/16/18.</p> <p>Interview on 10/25/18 with the Owner #2 revealed: -They had combined clients of this facility with their sister facility at the location of the sister facility. -They had staffing issues at one time. She also</p>	V 291	<p>Nebo Supervised Living received late notification from the state that our application to re-classify from a nine-bed facility to a six bed facility had been approved. Plans already existed regarding which resident would be required to move, but he had not been physically relocated. Individual in question was relocated successfully and the bed that had been used by said individual was also removed from the facility to remove the possibility that another individual could reside within the facility.</p>	

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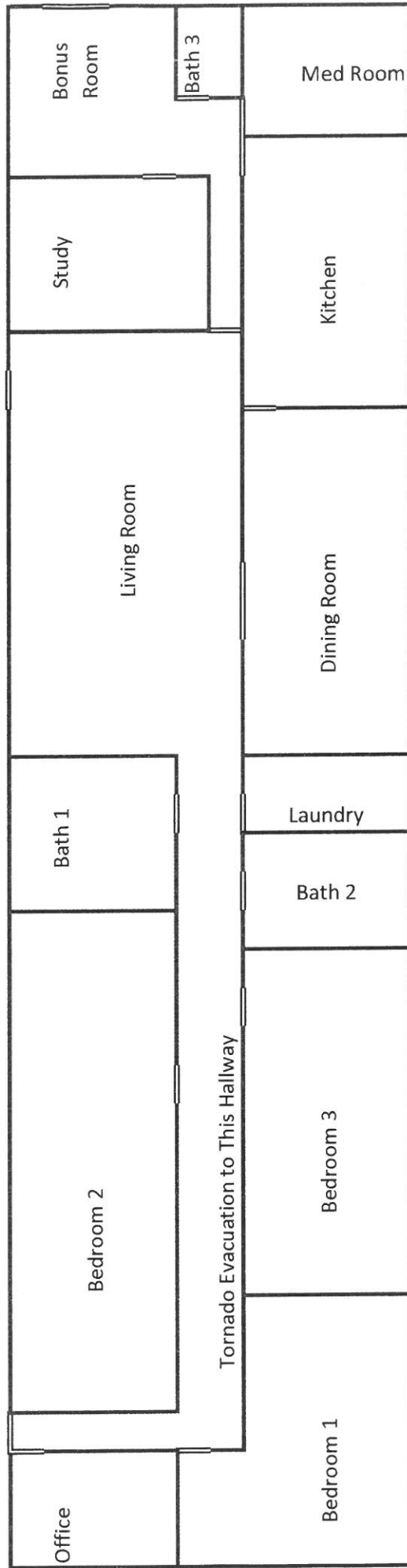
NAME OF PROVIDER OR SUPPLIER  <b>NEBO SUPERVISED LIVING</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2121 OLD HWY #10 EAST</b> <b>NEBO, NC 28761</b>
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V 291	Continued From page 3  stated that the sister location had more room and activities that they all could participate in. -They felt that the clients enjoyed being with the clients of the sister facility. -They had stopped combining the homes during the course of the survey. -They now had staff for each facility. -They were in the process of lowering the capacity to 4 for each facility.	V 291	Visits between the facilities have been limited. Time spent by the sister facility (West Marion Group Home) at the Nebo Supervised Living Facility is predominantly limited to Sunday and an occasional week day as necessary to engage in community inclusion. While the West Marion individuals have expressed mild to severe disappointed about not spending as much time with their friends as they once did, they seem to understand the state restrictions on occupancy.	

Image NOT TO SCALE



Fire Evacuation Area is by the Dumpster



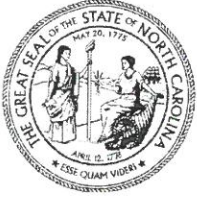
X = You Are HERE  
- - - = Follow this path

2018 Fire Drills		
Site	Quarter	Date
Lukin	First	
	First	
	First	
	Second	
	Second	
	Second	
	Third	
	Third	
	Third	
	Fourth	
Nebo	First	
	First	
	First	
	Fourth	12/03/2018
		10/26/2018
		11/13/2018
		11/17/2018
		10/30/2018
		11/17/2018
		12/07/2018

2018 Disaster Drills		
Site	Quarter	Date
Lukin	First	
	First	
	First	
	Second	
	Second	
	Second	
	Third	
	Third	
	Third	
	Fourth	
Nebo	First	
	First	
	First	
	Fourth	12/16/2018
		10/29/2018
		11/16/2018
		11/20/2018
		11/02/2018
		11/20/2018
		12/20/2018

2019 Fire Drills		
Site	Quarter	Date
Lukin	First	01/03/2019
	First	02/09/2019
	First	03/07/2019
	Second	04/20/2019
	Second	05/12/2019
	Second	06/06/2019
	Third	07/11/2019
	Third	08/12/2019
	Third	09/07/2019
	Fourth	10/28/2019
Nebo	First	11/15/2019
	First	12/05/2019
	First	01/07/2019
	First	02/13/2019
		03/11/2019
		04/24/2019
		05/16/2019
		06/10/2019
		07/15/2019
		08/16/2019
		09/11/2019
		11/01/2019
		11/19/2019
		12/09/2019

2019 Disaster Drills		
Site	Quarter	Date
Lukin	First	01/06/2019
	First	02/14/2019
	First	03/16/2019
	Second	04/24/2019
	Second	05/18/2019
	Second	06/14/2019
	Third	07/22/2019
	Third	08/15/2019
	Third	09/20/2019
	Fourth	10/31/2019
Nebo	First	11/18/2019
	First	12/18/2019
	First	01/10/2019
	First	02/18/2019
		03/20/2019
		04/28/2019
		05/22/2019
		06/18/2019
		07/26/2019
		08/19/2019
		09/24/2019
		11/04/2019
		11/22/2019
		12/22/2019



NC DEPARTMENT OF  
**HEALTH AND  
HUMAN SERVICES**

ROY COOPER • Governor  
MANDY COHEN, MD, MPH • Secretary  
MARK PAYNE • Director, Division of Health Service Regulation

November 15, 2018

Betsy Burleson, Owner  
North Carolina Outreach Group Homes, LLC  
PO Box 249  
Nebo, NC 28761

Re: Annual and Follow up Survey completed October 25, 2018  
Nebo Supervised Living, 2121 Old Highway #10E, Nebo, NC 28761  
MHL # 059-036  
E-mail Address: [betsyburleson@yahoo.com](mailto:betsyburleson@yahoo.com)

DHSR - Mental Health  
DEC 03 2018  
Lic. & Cert. Section

Dear Ms. Burleson:

Thank you for the cooperation and courtesy extended during the annual and follow up survey completed October 25, 2018.

As a result of the follow up survey, it was determined that all of the deficiencies are now in compliance, which is reflected on the enclosed Revisit Report. Additional deficiencies were cited during the survey.

Enclosed you will find all deficiencies cited listed on the Statement of Deficiencies Form. The purpose of the Statement of Deficiencies is to provide you with specific details of the practice that does not comply with state regulations. You must develop one Plan of Correction that addresses each deficiency listed on the State Form, **and return it to our office within ten days of receipt of this letter.** Below you will find details of the type of deficiencies found, the time frames for compliance plus what to include in the Plan of Correction.

**Type of Deficiencies Found**

- The tags cited are standard level deficiencies.

**Time Frames for Compliance**

- Standard level deficiencies must be **corrected** within 60 days from the exit of the survey, which is December 24, 2018.

**What to include in the Plan of Correction**

- Indicate what measures will be put in place to **correct** the deficient area of practice (i.e. changes in policy and procedure, staff training, changes in staffing patterns, etc.).
- Indicate what measures will be put in place to **prevent** the problem from occurring again.
- Indicate **who will monitor** the situation to ensure it will not occur again.
- Indicate **how often** the monitoring will take place.
- Sign and date the bottom of the first page of the State Form.

Make a copy of the Statement of Deficiencies with the Plan of Correction to retain for your records. **Please do not include confidential information in your plan of correction and please remember never to send confidential information (protected health information) via email.**

**NC DEPARTMENT OF HEALTH AND HUMAN SERVICES • DIVISION OF HEALTH SERVICE REGULATION**

LOCATION: 1800 Umstead Drive, Williams Building, Raleigh, NC 27603  
MAILING ADDRESS: 2718 Mail Service Center, Raleigh, NC 27699-2718  
[www.ncdhs.gov/dhsr](http://www.ncdhs.gov/dhsr) • TEL: 919-855-3795 • FAX: 919-715-8078

AN EQUAL OPPORTUNITY / AFFIRMATIVE ACTION EMPLOYER

**STATE FORM: REVISIT REPORT**

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER mhl-059036 <span style="float:right">Y1</span>	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT 10/25/2018 <span style="float:right">Y3</span>
NAME OF FACILITY NEBO SUPERVISED LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 2121 OLD HWY #10 EAST NEBO, NC 28761	

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix V0367	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # 27G .0604	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____	10/25/2018	LSC _____		LSC _____	
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____		LSC _____		LSC _____	

REVIEWED BY STATE AGENCY <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR <i>Kenn Roberts</i>	DATE 11-12-18
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REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
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FOLLOWUP TO SURVEY COMPLETED ON 1/19/2018	<input type="checkbox"/> CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? <input type="checkbox"/> YES <input type="checkbox"/> NO
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