STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C		(X3) DATE SURVEY COMPLETED
			A. BUILDING:		
MHL076-007		B. WING	B. WING		
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	E, ZIP CODE	
MANGUM	HOUSE	841 EAS	T PRITCHARD ST	REET	
WANGUW	HOUSE	ASHEBO	RO, NC 27203		
(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 CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE COMPLETE
V 000	INITIAL COMMENTS		V 000		
	An annual, follow-up and complaint survey was completed on January 22, 2019. The complaints were substantiated (intake #NC00147510 & #NC00147549). There were deficiencies cited.				
	category: 10A NCAC	d for the following service 27G. 5600E Adults with Substance			
V 106	27G .0201 (A) (8-18) POLICIES	(B) GOVERNING BODY	V 106		
	27G .0201 (A) (8-18) (B) GOVERNING BODY POLICIES 10A NCAC 27G .0201 GOVERNING BODY POLICIES (a) The governing body responsible for each facility or service shall develop and implement written policies for the following: (8) use of medications by clients in accordance with the rules in this Section; (9) reporting of any incident, unusual occurrence or medication error; (10) voluntary non-compensated work performed by a client; (11) client fee assessment and collection practices; (12) medical preparedness plan to be utilized in a medical emergency; (13) authorization for and follow up of lab tests; (14) transportation, including the accessibility of emergency information for a client; (15) services of volunteers, including supervision and requirements for maintaining client confidentiality; (16) areas in which staff, including nonprofessional staff, receive training and continuing education; (17) safety precautions and requirements for				

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

(X6) DATE TITLE

	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		
		MHL076-007	B. WING	B. WING		R I/ 22/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
MANGUM	HOUSE	841 EAS	T PRITCHARD STE	REET		
WANGOW	THOUSE	ASHEBO	DRO, NC 27203			
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
V 106	areas; and (18) client grievance	policy, including procedures ition of client grievances. verning body shall be	V 106			
	facility management f transportation policy. Review on 1/22/19 of response policy dated -"The Program has e procedures to assist e various emergency si	and record reviews, the ailed to adhere to its The findings are: the facility's emergency d 4-16-02 revealed: established a variety of employees in responding to tuations. Employees are ese procedures in order to				
	-"Some Program em owned vehicles or the providing services. As drives a motor vehicle that can be decrease equipment (seat belt) maintenance, and ski	ployees may drive agency eir personal vehicle in es is the case when anyone e, there are potential risks d with the use of proper , proper care and lls in defensive driving. The to the care and up-keep of				
	for the van revealed: -Serviced dated 12/16 wipers, lights and trar -Serviced dated 1/12/					

Division of Health Service Regulation

STATE FORM 8899 39WE11 If continuation sheet 2 of 8

Division of Health Service Regulation						
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING:		COMPLI	ETED
					F	.
		MHL076-007	B. WING		1	22/2019
					1 01/2	.2/2013
NAME OF PE	ROVIDER OR SUPPLIER		DDRESS, CITY, STA			
MANGUM	HOUSE		T PRITCHARD S	STREET		
			PRO, NC 27203	T		T.
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
TAG	,	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE		DATE
				DEFICIENCY)		
V 106	Continued From page	e 2	V 106			
		, <u> </u>				
	Observation on 1/17/	18 at 10:00 - 10:30 a.m. of				
	the facility's van revea				ļ	
	-Twelve seat van.	alcu.				
		torn with metal rod exposed.			ļ	
		with metal rod exposed.			ļ	
	-Passenger seat torn	with metal rod exposed.				
		s dirty, stained and cushion			ļ	
	torn with metal expos				ļ	
		ext to the door seatbelt and			ļ	
		broke and not working.			ļ	
		near door seatbelt was				
	broken.	assenger side of the door			ļ	
	panel did not latch on				ļ	
		edges or metal edges			ļ	
	sticking out.	reages of metal sages				
	Interview on 1/18/19	with Staff #1 revealed:				
	-He worked at the fac	•				
		cility for about 4 years.				
	•	o programs, appointments				
	and other services.					
	-Denied any client fall	•				
		opening while driving. client at the other facility				
	was scratched by a m					
	_	plems with the van to Lead				
	Support Staff.	nome war are van te zead				
		vould get the van serviced				
	and fixed.	· ·				
		with Staff #4 revealed:				
	-She worked at the wo	omen's facility.				

men's facility.

and appointments.

-She shared van with the men facility.

-She also had to pick up the male clients from the

-One of the women was scratched on the leg by a

-She transported clients to programs, services

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DIVISION C	of Health Service Regu	liation				
STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		_				
			B. WING		R	
		MHL076-007	B. WING		01/2	2/2019
NAME OF PR	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	ΓΕ, ZIP CODE		
		841 EAS	PRITCHARD S	TREET		
MANGUM	HOUSE		RO, NC 27203			
			,			
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
TAG	,	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR		DATE
				DEFICIENCY)		
\/ 40C	0 (15	2	V 106			
V 106	Continued From page	3	V 106			
	metal piece sticking of	out of the van seat.				
		ility removed the metal				
	object.	•				
	-First aid provided bu	t no bleeding occurred.				
		opened while she was				
	driving.	•				
		f any client male or female				
	"almost" falling out the					
	-The van would get so	erviced when problems were				
	reported.					
	-The facility needed a	a new van.				
	Interview on 1/22/19	with the Lead Support Staff				
	revealed:					
	-Staff transported clie	ents from the men and				
	women's facility.					
	-There were no repor	ts of client injuries.				
	-He would get the var					
	-He was aware of the	broken seat belts and van				
	door.					
		etting the seat belts and van				
	door fixed.					
	-The facility needed a					
	-Van was serviced 12	2/16/18 and 1/12/19.				
		with the Administrator				
	revealed:					
		e problems with the van.				
		ed as reported by staff and				
	as needed.					
		of any injuries that occurred				
	on the van.					
		management entity for				
	funding to purchase a					
		to fix the van to prevent				
	injuries.					
V 115	27G 0208 Client Ser	vices	V 115			

Division of Health Service Regulation

STATE FORM 8899 39WE11 If continuation sheet 4 of 8

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
				R		
		MHL076-007	B. WING		01/22/2019	
NAME OF PROVIDER OR SUPPLIER STREET ADD			DRESS, CITY, STA	TE, ZIP CODE		
MANGUM	HOUSE		PRITCHARD S	TREET		
040.15	CLIMMADV CT	ATEMENT OF DEFICIENCIES	RO, NC 27203	PROVIDER'S PLAN OF CORRECTION	1 0/5	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
V 115	Continued From page 4		V 115			
	10A NCAC 27G .0203 (a) Facilities that provassure that: (1) space and supervithe safety and welfard (2) activities are suita and treatment/habilitate served; and (3) clients participate activities. (h) Facilities or prograin these Rules as "24 available 24 hours a cunless otherwise special that served in the served; and with secure adaptive (e) When two or more require special assistin a vehicle are transported.	ision is provided to ensure e of the clients; ble for the ages, interests, ation needs of the clients in planning or determining ams designated or described chour" shall make services day, every day in the year. Cified in the rule. The or prepare meals for the meals are nutritious. In have a physical handicap rehicle shall be equipped equipment. The preschool children who cance with boarding or riding ported in the same vehicle, ult, other than the driver, to				
	failed to ensure servi	ew and interview, the facility ces were made available 24 ay in the year for 7 of 7				
	Interview on 1/17/19 with Client #2 revealed: -He lived at the facility at the time of the winter					

Division of Health Service Regulation

STATE FORM 8899 39WE11 If continuation sheet 5 of 8

Division of Health Service Regulation							
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING: _		COMPL	EIED	
MHL076-007		B. WING		R 01/22/2019			
NAME OF PF	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE			
MANCHM	HOUSE	841 EAS	T PRITCHARD S	TREET			
MANGUM	HOUSE	ASHEBO	PRO, NC 27203				
(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 CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE	
V 115	Continued From page	÷ 5	V 115				
	weather storm. -The electricity was on the storm. -They did not attend poor the electricity went of the electricity was on the electricity went of the electricity we	ort for about 3-4 days due to corograms. Out in the area. ers at the women 's facility ation. r; it was cold. t the facility during the d flashlights. m fast food restaurants for cricity. shift oven outside the house it down.					
	-He lived at the facility outThey offered us to ta s facilityFC#8 made a make some -The facility provided flashlights.						
	freezer.	na griilea 100a 110111 tille					
	outReported no staff at t	when the electricity went the facility during the storm.					

-Staff did not get us any food.

provided food throughout the day. -Staff provided flashlights and candles.

-When asked question again, he reported staff

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Division o	of Health Service Regu	lation			FORM	1 APPROVED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
MHL076-007		MHL076-007	B. WING		R 01/22/2019	
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
MANGUM	HOUSE		T PRITCHARD S	TREET		
	ASHEB					
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
V 115	Continued From page	e 6	V 115			
	-There was water but	it was cold.				
	Nata, athan alianta wa					
	storm or not at facility	as either not admitted during				
	Storm of not at lacility	during survey.				
	Interview on 1/22/19	with the Lead Support Staff				
	revealed:					
	-He and staff #2 work	ed during the storm.				
	-He worked most of the					
	-Electricity went out o	n Friday and back on				
	Sunday about noon.					
	-Food was provided t					
		t, lunch and dinner and food				
	donated from soup ki					
	ate certain foods.	n with the food; FC#8 only				
		and candles but the water				
	was cold.	and sandies but the water				
	-He learned FC#8 ma	ade a make shift oven but				
	was asked to take it of	down.				
		all the time which was due to				
	his discharge.					
	Interview on 1/22/19	with the Administrator				
	revealed:					
	-Staff was available d	•				
	-There was always st					
		went out but did not think				
	relocation was neede					
	-There was water but	to take showers at the				
	women 's house.	to take showers at the				

freezer.

early Sunday.

food take out by staff.

-Staff also grilled in the backyard.
-They had a lot of food in the freezer.

-Food was provided by the soup kitchen and fast

-All the food in the refrigerator was placed in the

-The electricity went out Friday and came back on

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PRINTED: 01/31/2019 FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

R / 22/2019
/22/2019
(X5) COMPLETE DATE

Division of Health Service Regulation

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