Division of Health Service STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		IV21 DATE	CHO
		DENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED
					1 .	
	MHL007-026		B. WING		R 11/07/2018	
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY	STATE, ZIP CODE	1 11/0	112010
BEAUFO	RT COUNTY GROUP	HOME #1 405 EAST	F 6TH STRE	ET		
		WASHING	STON, NC	27889		1
(X4) ID PREFIX	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT	ION	
TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO	II D DE	(X5) COMPLETE
				DEFICIENCY)	PRIATE	DATE
V 000	INITIAL COMMENT	rs	V 000			
	An one			D:-		1
	on November 7 20	w-up survey was completed		DHSR - N	lone	
	on November 7, 20	18. A deficiency was cited.		DHSR - M	ental H	alth
	This facility is licens	sed for the following service		NOV a	0.00	
	category, TUA NCAC 2/G 5600C Supervised			NOV 2	0 2018	
	Living for Adults with	h Developmental Disabilities.		Lic. & c		
1				Lic. & Cert	Section	
V 230	27G .5602 Supervis	ed Living - Staff	V 290	Clen + # 3 Room A	YIX	1 1
	10A NCAC 27G .56	02 STAFF	a	Client # 3 Belord	clea	14 Cl
	(a) Staff-client ratio	s above the minimum				
	numbers specified in	Paragraphs (h) (c) and (d)		and documentate Mient# 3's unsu	100 0	Lavel
	or this rule shall be	determined by the facility to		M. 1 + 3 15 11 200	1.	J. a. a.
	needs.	and to individualized client		011 mt 3 3 00184	phois	re dtspr
14.5		ne staff member shall be		wi ormron in sh	nday	
	present at all times v	When any adult client is on the		mornings.	Id	
1.1	premises, except wr	en the client's treatment or		A towns no		1 11
1.1	iabilitation plan doci	uments that the client in		A tenm metina on 1/9/2018. Clock	y was	nela
1	Without supervision	in the home or community The plan shall be reviewed		ON 1/9/2018 Chen	1 # 3	3
	as theeded put UOI le	SS than annually to encure		Brong Home Staff #2, and Natura	11-1	1
	he client continues t	O be capable of remaining in		#2 ATAM	一年1	ma
	the Hottle of COMMU	nity without supervision for		a natura	LSUP	pnts
1	specified periods of t	lime.	-	rom the 15th St.	1 has	11- 27
f	ollowing client-staff	sent in a facility in the ratios when more than one	ľ	Mrietin Wall :	- rout r	noit
	addlescent c	lient is present		thrist in Washing	tong (45 Wiss
(1) Children or	adolescents with substance	9	ruspmsibilities	- 11/1	18 pm
а	ibuse disorders shall	be served with a minimum		450m (1 1 1 2)	0	(300)
C	lients present How	or every five or fewer minor	+	T. J. SIDIUTIES	or yr	Supen
p	resent during sleepi	vever, only one staff need being hours if specified by the	1	. Chen	1 # 4	1 4
-	mergency back-up t	procedures determined by		MIS DINN MISS	, ,	-3
u	ie governing body; o	or		his own gnar di	an ar	10
	2) children or a	adolescents with		INCHUNTHER SINV	1001	had
0	ne staff present for	lities shall be served with every one to three clients		KNOWN Climatit		mi
P	tesent and two statt	present for every four or	(Mars to told	111	many
on or mean	In Service Regulation			KNOWN Client H3 gears to Enchade	berr	14 10
TALLORY DI	RECTOR'S OR PROVIDER	VSUPPLIER REPRESENTATIVE'S SIGNA	TURE	TITLE		
E FORM	us. tu	Urv.s. QP/BA	K/K	deatid Some	(X6)	DAYE 11/2
- PUKIN		/ / /	1001	-VIOTIAI -VIVI (1	VIADA	11/1

Division of Health Service Regulation FORM APPROVED						
STATEME	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL007-026	B. WING		R 11/07/2018	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE	11/0//2018	
BEAUFORT COUNTY GROUP HOME #1 405 EAST 6TH STREET WASHINGTON, NC 27889						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED DEFICIENCY)	D RE COMPLETE	
V 290	more clients present due specified by the emodetermined by the g (d) In facilities whice diagnosis is substar (1) at least on duty shall be trained withdrawal symptom secondary complicating addiction; and (2) the service	t. However, only one staff ring sleeping hours if ergency back-up procedures overning body. In serve clients whose primary ace abuse dependency: It is staff member who is on in alcohol and other drug as and symptoms of tions to alcohol and other ess of a certified substance all be available on an	V 290	the Church programment that Church programment of the Hard Super S	opents will ouring ad time services.	
x1_	facility failed to ensu habilitation plan docucapable of remaining supervision for specithree of three auditer findings are: Review on 11/07/18 - 71 year old female. Admission date of Diagnoses of Mode Developmental Disal Schizophrenia, and Ferson-Centered Person-Centered Person-Centered Pergarding client #1's	iew and interviews, the re a clients' treatment or amented the client was in the community without fied periods of time affecting d clients (#1, #2 and #3). The of client #1's record revealed: 10/09/13. Trate Intellectual collity (IDD), Unspecified distory of Breast cancer. Frofile (PCP) dated 05/23/18. Intain any documentation unsupervised time at church		Church each Shir From 9:30 Am un Which IS When S STAKF # 2 return NP Client #3 Fi Service. Church Service Church Service Wednesday nights Stark I AL # 2 Wi Hansport Chunch Stark # I and	SATTHIS WILLSON SATTHIS WILL ON SATTHIS WILL ON SETTING 11 a ISD +3.	
2	on Sunday mornings Review on 11/07/18 o - 53 year old female.	of client #2's record revealed:		ensure that Na Support pusm to	59 mays	
	alth Service Regulation			In Placeto accep	thoroge	

Division of Health Service Regulation FORM APPROVED							
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTI	PLE CONSTRUCTION	(V2) DATE OUT			
AND PLAI	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDIN		(X3) DATE SURVEY COMPLETED		
		MHL007-026	B. WING		R		
NAME OF	PROVIDER OR SUPPLIER				11/07/2018		
				, STATE, ZIP CODE			
BEAUFO	BEAUFORT COUNTY GROUP HOME #1 405 EAST 6TH STREET WASHINGTON, NC 27889						
(X4) ID PREFIX	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION)NI		
TAG	REGULATORY OR LS	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOUL	DRF	(X5) COMPLETE	
			TAG	CROSS-REFERENCED TO THE APPROI DEFICIENCY)	PRIATE	DATE	
V 290	Continued From page	ne 2	14000				
	- Tom pa		V 290	95 Natural Sup	post	1	
	- Admission date of	12/07/09.		ouring uneupon	ise a	1	
	Congostive Heart for	erate IDD, Sleep Apnea and		Time and	MACH		
	Congestive Heart fa - PCP dated 06/20/1	illure.		Time during o	murp	10	
-	- The PCP did not o	ontain any documentation		before Stark Year		1	
	regarding client #2's	unsupervised time at church		Now STOUT CERT	13 +	-he	
	on Sunday mornings	S.		Pramises. Mata	roll		
3-	Review on 11/07/18	7/18 of client #3's record revealed:		Supports will be	recp	msoth.	
	- 60 year old male.	or cheft #3's record revealed:		L 0 0 11		1	
	- Admission date of	09/24/81.		to can Group H.	o me 1	+1	
	- Diagnoses of Seve	re IDD. Autism Spectrum	STATE HIN#2 to Info				
	Disorder and Seizur	e Disorder.		nfom			
	- PCP dated 08/31/18 The PCP did not contain any documentation		-	vill b	~		
	regarding client #3's	unsupervised time at church		0.77			
	on Sunday mornings	s.		anavailable, or	mot b	e at	
	Intension on 11/06/4	0 -1: 44		Church well het	,		
	Interview on 11/06/18 client #1 stated: - She had lived at the facility for 5 years She attended Church every Sunday morning Staff would take her and some of her peers to a			lack the tree the	ou so	TUS top	
				Whenever this o	MALLEN		
				Oben + #3 Will ha	Coor	2	
	local Church. The sta	aff would drop off her and her			ve ti	na I.	
	peers and pick them up after the service Staff did not stay with clients at the Church Service.			option to either	VOF 1	Hend	
				Services, or STAFF	110	+1	
	Infanda			Lill Ch	- 100		
	Interview on 11/06/18 client #2 stated: - She went with some peers to a local Church on			Will Stay with a	Tuna	1-4-3	
	Sundays.	e peers to a local Church on	_	thring is I H. Co-		1	
		lients off at Church and		thrn-but the ser	vers	as	
	picked them up later	after the service.		their not be alow	100	1	
				their nill be No	uish	BUVISIC	
1	Interview on 11/07/18	staff #1 stated:		Support any other			
	- She took some of the	the facility since 1998.		Span	LNAS	ural	
	on Sunday mornings.	ne clients to a local Church	1	7 - 1	1		
		off with someone who is		This inter-	, /	,	
-	familiar with the clien	ts and she picked them up		L. d	fin 1	V. 11	
	after the service.	- Franco mon up		this intermated in	nai		
ision of He	alth Service Regulation			1000	11 4	in	

PRINTED: 11/09/2018 FORM APPROVED

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF A. BUILDING	PLE CONSTRUCTION G:	(X3) DATE SURVEY COMPLETED		
		MHL007-026			R 11/07/2018	
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
BEAUFO	ORT COUNTY GROUP		T 6TH STRE GTON, NC 2			
(X4) ID PREFIX	SUMMARY STA	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION	ON (X5)	
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D.BE COMPLETE	
V 290	- Client #1, #2 and # every Sunday She would take the Sunday mornings. Safter approximately Interview on 11/07/1 stated: - Client #1, #2 and # Someone familiar w supervision while at - She understood the needed to indicate to clients cold be left u community.	18 staff #2 stated: t the facility for 2 years. #3 attended a local Church e 3 clients to Church on She would pick the clients up 2 hours. 8 the Qualified professional #3 went to a local church. ith the clients provided Church. e client's treatment plans he specified periods of time	V 290	#3's (PCP) by A Team Mueti be held as nece and updated v there are any Time for the correct The PP, and t Team to enclude the 3 and Matur and Starf 41 by and all copa	JUIZELIS MENTER When wer When wer When wer Menter	