STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL026-960	A. BUILDING: _____ B. WING _____	R 05/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY ALTERNATIVE HOUSING, INC	1410 SEABISCUIT DRIVE PARKTON, NC 28371

(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
V 000	INITIAL COMMENTS An annual and follow up survey was completed on May 15, 2019. A deficiency was cited. This facility is licensed for the following service category: 10A NCAC 27G. 5600F Supervised Living/Alternative Family Living.	V 000		
V 112	27G .0205 (C-D) 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		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL026-960	A. BUILDING: _____ B. WING _____	R 05/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY ALTERNATIVE HOUSING, INC	1410 SEABISCUIT DRIVE PARKTON, NC 28371

(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
V 112	Continued From page 1 This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to develop and implement strategies based on assessment affecting one of one clients (#1). The findings are: Review on 05/14/19 of client #1's record revealed: - 14 year old female. - Admission date of 08/08/15. - Diagnoses of Moderate Intellectual Developmental Disability and Down's Syndrome. Review on 05/14/19 of client #1's Individual Support Plan (ISP) dated 09/01/18 revealed: - "What People Like And Admire About Me...The designated QP (Qualified Professional) and AFL (Alternate Family Living) operator report [Client #1] is not sleeping throughout night and attempting to move about the house and needs 24-hour awake staff to ensure her safety." Review on 05/14/19 of a "Support Needs Assessment" for client #1 and dated 07/24/18 revealed: - Client #1 requires an awake staff at night. - "Client lives in an AFL. Has history and recent incidents of eloping, rambling at night while family was asleep. Able to unlock most conventional door locks." Review on 05/14/19 of the facility staff list provided by the AFL revealed one staff provided care at the facility. Interview on 05/14/19 the QP stated: - Staff #1 was the AFL provider. - No other staff worked at the facility. - She would address the need of 24 hour	V 112		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL026-960	A. BUILDING: _____ B. WING _____	R 05/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY ALTERNATIVE HOUSING, INC	1410 SEABISCUIT DRIVE PARKTON, NC 28371

(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
V 112	Continued From page 2 supervision with awake staff for client #1 with the Care Coordinator who completed the ISP.	V 112		