Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
				С			
MHL047-168		B. WING		05/29/2019			
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
SISTERLY LOVE 170 CLUB POND ROAD							
	T		D, NC 28376				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE COM		(X5) COMPLETE DATE	
V 000	INITIAL COMMENTS		V 000				
	2019. The complain #NC00151964). De	was completed on May 29, at was unsubstantiated (intake ficiencies were cited. ed for the following service C 27 G .5600A Supervised h Mental Illness					
V 290	27G .5602 Supervis		V 290				
	10A NCAC 27G .5602 STAFF (a) Staff-client ratios above the minimum numbers specified in Paragraphs (b), (c) and (d) of this Rule shall be determined by the facility to enable staff to respond to individualized client needs. (b) A minimum of one staff member shall be present at all times when any adult client is on the premises, except when the client's treatment or habilitation plan documents that the client is capable of remaining in the home or community without supervision. The plan shall be reviewed as needed but not less than annually to ensure the client continues to be capable of remaining in the home or community without supervision for specified periods of time. (c) Staff shall be present in a facility in the following client-staff ratios when more than one child or adolescent client is present: (1) children or adolescents with substance abuse disorders shall be served with a minimum of one staff present for every five or fewer minor clients present. However, only one staff need be present during sleeping hours if specified by the emergency back-up procedures determined by the governing body; or (2) children or adolescents with developmental disabilities shall be served with						

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·			(X3) DATE SURVEY COMPLETED	
			A. BUILDING:				
MI		MHL047-168	B. WING		C 05/29/2019		
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
SISTERLY LOVE 170 CLUB P							
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE	
V 290	Continued From page 1 present and two staff present for every four or more clients present. However, only one staff need be present during sleeping hours if specified by the emergency back-up procedures determined by the governing body. (d) In facilities which serve clients whose primary diagnosis is substance abuse dependency: (1) at least one staff member who is on duty shall be trained in alcohol and other drug withdrawal symptoms and symptoms of secondary complications to alcohol and other drug addiction; and (2) the services of a certified substance abuse counselor shall be available on an as-needed basis for each client.		V 290				
	facility failed to asso having unsupervise without staff superv clients (#1). The fin Review on 5/29/19 -Admission date of -Diagnoses of Schit Disability, Diabetes -There was no door been assessed for	view and interviews, the ess a client's capability of ed time in the community vision affecting one of five dings are: of client #1's record revealed: 9/26/16. zophrenia, Intellectual and Hyperlipidemia. umentation that client #1 had					
	-He was allowed to community without -He would normally	t #1 on 5/29/19 revealed: have unsupervised time in the staff. walk to church on Sundays. ing to church without staff					

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STATE FORM 6899 HLEH11 If continuation sheet 2 of 3

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				DATE SURVEY COMPLETED	
			A. BUILDING.				
		MHL047-168	B. WING			<i>,</i> 9/2019	
NAME OF	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE						
SISTERLY LOVE 170 CLUB POND ROAD RAEFORD, NC 28376							
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE	
V 290	Continued From page 2		V 290				
	supervision for abo -He would normally about two hours.	ut a month. be away from the home for					
	Professional reveal -Client #1 had been the community with -Client #1 just rece unsupervised time -Client #1 would no time to go to church -Client #1's guardia time in the community -She did not realize unsupervised time -She confirmed the	n using unsupervised time in out staff. Intly started using the in the community. It is rmally use the unsupervised on Sundays. In approved the unsupervised					

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