STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL032-500	A. BUILDING: _____ B. WING _____	05/28/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY HOUSE II-DURHAM	409 EBON ROAD DURHAM, NC 27713

(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 complaint survey was completed on May 28, 2019. The complaint was unsubstantiated (intake #NC00151893). A deficiency was cited. This facility is licensed for the following service category: 10A NCAC 27G .5600A Supervised Living for Adults with Mental Illness.	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
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V 112	Continued From page 1 This Rule is not met as evidenced by: Based on record reviews and interview, the facility failed to develop a treatment plan for one of three audited clients (#5) and ensure the treatment plan included a crisis plan for one of three audited clients (#5). The findings are: Review on 5/28/19 of Client #5's record revealed: -Admission date of 3/1/19. -Diagnoses of Schizoaffective Disorder, Depressive Type; Bipolar Disorder, in Partial Remission, most Recent Episode Manic. -There was no treatment plan in the record. -There was no crisis plan in the record. Interview on 5/28/19 with the Program Manager revealed: -She was aware that Client #5's Person Centered Plan (PCP) was missing from her chart. -Agency had been waiting for Client #5's Assertive Community Treatment Team to complete the plan. -Plan had been scheduled to have PCP completed on 6/4/19. -The QP was responsible for ensuring treatment and crisis plans were completed. -She confirmed that a signed treatment and crisis plan for Client #5 was not in her chart.	V 112		