STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			
		MHL024-081	B. WING		07/1	7/2019
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
CAMPGI	CAMPGROUND HOUSE 475 CAMPGROUND ROAD WHITEVILLE, NC 28472					
0(1) 15	CLIMMA DV CTA		1		ON	()(5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
V 000	INITIAL COMMENT	rs	V 000			
	An annual survey w 2019. Deficiencies	vas completed on July 17, were cited.				
	category: 10A NCA	sed for the following service C 27G .5600C Supervised h Developmental Disabilities.				
V 291	27G .5603 Supervis	sed Living - Operations	V 291			
	six clients when the developmental disa on June 15, 2001, at than six clients at the provide services at licensed capacity. (b) Service Coordination of the service of the	cility shall serve no more than a clients have mental illness or bilities. Any facility licensed and providing services to more not time, may continue to no more than the facility's nation. Coordination shall be not the facility operator and the als who are responsible for on or case management. The Family or Legally note and the facility and visits outside a shall be submitted at least and of a minor resident, or the person of an adult resident. Writing or take the form of a sall focus on the client's peeting individual goals. The second of the second of the second of the second of the court involved or when health or me a primary concern.				

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

TITLE (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL024-081	B. WING		07/·	17/2019
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
CAMPG	ROUND HOUSE		PGROUND R LLE, NC 284			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
V 291	Continued From pa	ge 1	V 291			
	facility failed to mail with the qualified presponsible for trea (#3). The findings at Review on 7/15/19 record revealed: - 46-year-old female- Admission date of Schizophrenia -Chintellectual Disabilit Intermittent Explosi - Order dated 6/27/ Extended Release Take one tablet by - Order dated 6/27/ Losartan-Hydrochloone tablet by mouth-No order, policy/pr blood pressure (BP for response for restoo high or too low)	views and interviews, the ntain coordination of services ofessionals who are tment for 1 of 3 audited clients are: and 7/16/19 of client #3's e. 2/16/19 nronic Undifferentiated Type, y (Severe), Hypertension, and ve Disorder. 19 for Metoprolol Succinate-(ER) 25 milligrams (mg) - mouth daily (hypertension). 19 for orothiazide 100/25 mg- Take in daily (hypertension). ocedure, or guidelines with parameters and instructions sults that would be considered				
	Individual Support F revealed: - "Medical/Behavior	Plan (ISP) dated 4/01/19 alI have hypertension and to manage my blood				
	pressure." - "Medical/Behavior checked by the gropressure machine. pressure 1 to 2x we	alMy blood pressure is up home staff with a blood Staff check my blood eek or as needed. If my blood a contact [physician's] office or				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				ODATE SURVEY COMPLETED	
		MHL024-081	B. WING		07/	17/2019	
	NAME OF PROVIDER OR SUPPLIER CAMPGROUND HOUSE STREET ADDRESS, CITY, STATE, ZIP CODE 475 CAMPGROUND ROAD WHITEVILLE, NC 28472						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE	
V 291	- "Significant Events Stress/Trigger Crisis and require full suppressure. I require medications daily a pressure." - "Crisis Preventior Strategies Staff spressure and assist blood pressure medensure I maintain a check my blood pressure once or two blood pressu	(s) That May Cause Increased sKnow I have hypertension port to manage my blood full assistance with taking my nd checking my blood and Early Intervention hould monitor for high blood to [client #3] with taking her dications daily. Staff should low sodium diet. Staff should low sodium diet. Staff should essure 1-2 times per week. In for signs of headaches, or and checking my blood wice per week by use of a chine." Sis Response and Stabilization lood pressure begins to rise or evel, staff should contact or call 911." endations For Interacting With ing a Crisis ServiceStaff me for high blood pressure." 9 and 7/16/19 House Manager is not checked regularly due to hysician's order. Trameters or guidelines for staff allts that were too high or too in by her primary physician to sure. 9 the Qualified Professional of sished with client #3's primary eation of how to proceed with					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				OATE SURVEY OMPLETED	
		MHL024-081	B. WING		07/1	7/2019	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
CAMPGF	ROUND HOUSE		PGROUND R .LE, NC 284				
(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 SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE	
V 291	ensure staff were e - Client #3's ISP ha	aining was scheduled to ducated. d been developed by her Entity (LME) and not by her	V 291				
V 738	EXTERIOR REQUI	03 LOCATION AND	V 738				
	failed to keep the fa findings are: Observations on 7/ - Multiple ants, app crawling on top of the refrigerator, top of failing room table, and Interview on 7/15/19 She had not witnee 7/15/19 The facility had an sprayed to control in	on and interview, the Licensee acility free from insects. The 15/19 and 7/16/19 revealed: roximately ¼ inch in length, he kitchen counter, front of freezer, kitchen window blinds, and across surveyor. 8 the House Manager stated: ssed ants until the morning of					

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