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		(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED 08/28/2019		
	MHL086034					
VIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE, ZIP CODE				
#1		CE LILY LANE N, NC 27017				
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	CTION SHOULD BE COMPL D THE APPROPRIATE DAT		
INITIAL COMMENTS		V 000				
n August 28, 2019. T NC00153446) was u vas cited. his facility is licensed ategory: 10A NCAC	The complaint (Intake Insubstantiated. A deficiency d for the following service 27G .5600C Supervised					
7G .0205 (C-D) ssessment/Treatme	nt/Habilitation Plan	V 112				
REATMENT/HABILI PLAN c) The plan shall be ssessment, and in pro- egally responsible per- f admission for client eceive services beyond b) The plan shall incr chieved by provision rojected date of aching chieved by provision rojected date of aching	TATION OR SERVICE developed based on the artnership with the client or rson or both, within 30 days is who are expected to nd 30 days. lude: that are anticipated to be of the service and a evement; view of the plan at least on with the client or legally both; on or assessment of t; and r agreement by the client or a written statement by the					
	SUMMARY STA (EACH DEFICIENCY REGULATORY OR L IITIAL COMMENTS In annual and compla in August 28, 2019. T NC00153446) was u as cited. Inis facility is licenseed ategory: 10A NCAC ving for Adults with I 7G .0205 (C-D) ssessment/Treatmen DA NCAC 27G .0205 REATMENT/HABILI LAN D) The plan shall be ssessment, and in pa gally responsible pe i admission for client sceive services beyo D) The plan shall be ssessment, and in pa gally responsible pe i admission for client is client outcome(s) chieved by provision rojected date of achi consultation (consultation) chieved by provision rojected date of achi consultation (consultation) chieved by provision rojected date of achi consultation (consultation) chieved by provision rojected date of achi (consultation) chieved by provision rojected date of achi (consultation) consultation (consultation) consultation (consultation) (consultation	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) IITIAL COMMENTS In annual and complaint survey was completed in August 28, 2019. 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() The plan shall include: () client outcome(s) that are anticipated to be chieved by provision of the service and a cojected date of achievement; () strategies; () staff responsible; () a schedule for review of the plan at least nually in consultation with the client or legally esponsible person or both; (i) basis for evaluation or assessment of utcome achievement; and () written consent or agreement by the client or sponsible party, or a written statement by the ovider stating why such consent could not be	DOBSON, NC 27017 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG IITIAL COMMENTS V 000 In annual and complaint survey was completed in August 28, 2019. The complaint (Intake NC00153446) was unsubstantiated. A deficiency as cited. V 000 Inis facility is licensed for the following service ategory: 10A NCAC 27G .5600C Supervised ving for Adults with Developmental Disabilities. 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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED 08/28/2019	
		MHI 086034				
MHL086034 NAME OF PROVIDER OR SUPPLIER STF			ADDRESS, CITY, STATE	00	/20/2019	
PEACE LI	I V #1	103 PEA	CE LILY LANE			
		DOBSO	N, NC 27017			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIE!	E ACTION SHOULD BE COMP TO THE APPROPRIATE DA	
V 112	Continued From page	e 1	V 112			
	facility failed to develor in the treatment/habil	as evidenced by: ew and interviews, the op and implement strategies itation plan to address the ng 1 of 3 clients (#1). The				
	-An admission date of -Diagnoses of Severe Thoughts and Acts, H Adult Victim of Abuse -An assessment date assistance with bathi ambulatory, wears pu a regular diet, is forge assistance with nail of and scheduling appo	e Anxiety, Mixed Delusional learing Voices and History of ed 6/10/19 noting "needs ng and dressing, is Ill ups due to accidents, has etful at times, needs eare, toileting, mouth care				
	Professional (FQP) re -Had gone on Matern 2019 -Decided to resign as of her full-time emplo -Last day of work was	ity leave the end of April the QP due to the demands yment. s June 19, 2019				
	plans for the clients w of goals and strategie -Was not familiar with -"She must have bee					
		with the Administrator In				

3T7K11

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Division of Health Service Regulation STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL086034			(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED 08/28/2019	
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NAME OF PI	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE	, ZIP CODE		
PEACE LI	LY #1		ACE LILY LANE N, NC 27017			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEN	ACTION SHOULD BE COM TO THE APPROPRIATE DA	
	 V 112 Continued From page 2 Charge (AIC) revealed: The FQP was responsible for completing the treatment plans for all of the clients. The FQP was paid for completing all of the clients' treatment plans and updating them prior to her resigning. Was unable to locate a treatment plan for client #1 Would contact the FQP to see why client #1's treatment plan was not completed 		V 112			

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