Division of Health Service Regulation

DIVISION	n nealth Service Regu	lation				
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
					l R	,
MHL076-007		B. WING		1	8/2019	
		WITE076-007			10/1	0/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	ATE, ZIP CODE		
MANGUM		841 EAST	PRITCHARD S	TREET		
MANGUM	HOUSE	ASHEBOR	O, NC 27203			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE
TAG	REGULATORY OR L	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	RIATE	DATE
			-	BEI IOIEROT)		
V 000	INITIAL COMMENTS		V 000			
	An annual, follow-up a	and complaint survey was				
		r 18, 2019. The complaint				
	was substantiated (in	·				
	Deficiencies cited.	tano 111000 100 111).				
	Denoicholde dited.					
	This facility is licensed	d for the following service				
	category: 10A NCAC					
		Substance Abuse Adults				
V 106	27G 0201 (A) (8-18)	(B) GOVERNING BODY	V 106			
٧ ،٥٥	POLICIES	(b) GOVERNING BODT	100			
	1 OLIOILO					
	10A NCAC 27G .020	1 GOVERNING BODY				
	POLICIES					
	(a) The governing boo	dy responsible for each				
		Il develop and implement				
	written policies for the					
	•	s by clients in accordance				
	with the rules in this S	-				
		cident, unusual occurrence				
	or medication error;	,				
		mpensated work performed				
	by a client;	p a second				
	(11) client fee assess	ment and collection				
	practices;					
	•	dness plan to be utilized in a				
	medical emergency;	·				
		and follow up of lab tests;				
	. ,	cluding the accessibility of				
	emergency information	-				
		teers, including supervision				
	and requirements for	- ·				
	confidentiality;	5 -				
	(16) areas in which st	aff, including				
	nonprofessional staff,				ĺ	
	continuing education;				ĺ	
		ns and requirements for			ĺ	
	facility areas including					

areas; and

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Division of Health Service Regulation

STATEMENT OF DEFICIENCES AND PLAN OF CORRECTION INDICATE INDITITION NUMBER IN A BUILDING OF THE CONSTRUCTION A BUILDING OF THE COMMETTED ON TH	DIVISION	of Health Service Regu	lation				
MANGO PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE MANGUM HOUSE B41 EAST PRITCHARD STREET ASHEDROR, NC 27203 SUMMARY STATEMENT OF DEPICIENCIES PRIEFIX TAG (EACH DEPICIENCY MUST SE PRECEDED BY PULL PRECEDENCY FOR LSC IDENTIFYING INFORMATION) V 106 Continued From page 1 (18) client grievance policy, including procedures for review and disposition of client grievances. (b) Minutes of the governing body shall be permanently maintained. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility management failed to adhere to its transportation policy. The findings are: Review on 10/18/19 of the facility's service receipts for the van revealed:Serviced dated 6/4/19 regular maintenance serviceServiced dated 6/4/19 regular maintenance serviceServiced dated 8/6/19. Observation on 10/17/19 at 11:15 a.m. of the facility's revealed:Twelve seat vanDriver seat material from with metal rod exposedPries row seating was drivy, stained and cushion torn with metal rod exposedPries row seating was drivy, stained and cushion torn with metal exposedFirst row and seaf next to the door seatbelt and plastic covering was broke and not workingSecond row seating near door seatbelt was broken. Interview on 10/17/19 with Clients available #1, #2, #3, #5, #7, #9 revealed:They had no problems with the van.			(X2) MULTIPLE CONSTRUCTION				
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Interview on 10/17/19 with Clients available #1, #2, #3, #5, #7, #9 revealed: -They had no problems with the van.		•	near door seathert was				
#2, #3, #5, #7, #9 revealed: -They had no problems with the van.		broken.					
#2, #3, #5, #7, #9 revealed: -They had no problems with the van.							
-They had no problems with the van.		Interview on 10/17/19	with Clients available #1,				
		#2, #3, #5, #7, #9 rev	ealed:				
		-They had no problem	ns with the van.				
		-					
-Confirmed the facility needed a new van due to							

Division of Health Service Regulation

wear and tear on the inside of the van.

STATE FORM 6899 545B11 If continuation sheet 2 of 8

PRINTED: 10/22/2019

Division of Health Service Regulation							
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			A. BUILDING:		COMPLETED		
			7 50.25		_	_	
			D. MINO		R		
		MHL076-007	B. WING		10/1	8/2019	
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	ATE, ZIP CODE			
		841 EAS	T PRITCHARD S	TREET			
MANGUM	HOUSE	ASHEBO	RO, NC 27203				
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	١	(X5)	
PREFIX	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE DATE	
TAG	REGULATORY OR L	-SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	CIATE	DAIL	
				,			
V 106	Continued From page	2	V 106				
	-Staff transported clie	ents to programs and other					
	appointments.						
	Interview on 10/17/19	with Staff #1 revealed:					
	-He worked various sl	hifts.					
	-He transported client	ts to programs.					
	-The van was service						
	-The Lead Staff would	d take van for service.					
	-He had no problems						
	-"Its running pretty sm						
	Interview on 10/17/19	with the Administrative Staff					
	revealed:						
	-She worked as supp	ort staff at the women's					
	facility since December						
	-Moved to administrat	tive staff as of 5/2019 at the					
	women's facility.						
	-She transported clier	nts at the women's facility.					
	-The van was shared	with the men's facility.					
	-She had no problems	s with the van.					
	-The van was service	d.					
	-She felt safe driving	the van.					
	Interview on 10/17/19	with the					
		ed Professional revealed:					
	· ·	taff took van for service.					
		taff was responsible for					
	maintenance of the va	•					
	-Lead Support Staff c						
		van had not been fixed					
	regarding wear and te						
	-The van sliding door						
		ssible merge with another					
	· · · · · · · · · · · · · · · · · · ·	•					
	, organization that wou	lld provide funding for a new	- 1				

Division of Health Service Regulation

van.

-The Lead Support Staff would continue to

and must be corrected within 30 days.

This deficiency constitutes a re-cited deficiency

monitor and serviced the van.

STATE FORM 6899 545B11 If continuation sheet 3 of 8

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
MHL076-007		B. WING		R 10/18/2019		
NAME OF PR	ROVIDER OR SUPPLIER		DDRESS, CITY, STA	TE, ZIP CODE	10/10/2013	
MANGUM	HOUSE		PRITCHARD S RO, NC 27203	TREET		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
V 110	SUPERVISION OF P. (a) There shall be not paraprofessionals. (b) Paraprofessionals associate professional as specific Subchapter. (c) Paraprofessionals knowledge, skills and population served. (d) At such time as a employment system in then qualified professionals shall defend the competence shall exhibiting core skills in the competence shall	A COMPETENCIES AND ARAPROFESSIONALS privileging requirements for a shall be supervised by an all or by a qualified fied in Rule .0104 of this a shall demonstrate abilities required by the competency-based as established by rulemaking, ionals and associate emonstrate competence. If be demonstrated by including: dge; sss; lls; kills; and dy for each facility shall int policies and procedures a individualized supervision in paraprofessional.	V 110			
This Rule is not met as evidenced by: Based on record reviews and interviews one of						

Division of Health Service Regulation

STATE FORM 6899 545B11 If continuation sheet 4 of 8

Division of Health Service Regulation							
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		MHL076-007	B. WING		R 10/18/2019		
NAME OF PF	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STATE	E. ZIP CODE			
			T PRITCHARD STI				
MANGUM	HOUSE		RO, NC 27203				
(X4) ID	SUMMARY ST.	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N (X5)		
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE		
V 110	Continued From page	e 4	V 110				
	three staff (#3) failed	to demonstrate the					
	` ,	l abilities required by the					
	Daview on 10/17/10 (of staff #3's record revealed:					
	-No record to review.						
	140 100014 10 10115						
	Interview on 10/17/19 revealed:	9 with the Administrative Staff					
		12/18 as Support Staff.					
	-Promoted to Adminis						
	-She worked at the w						
	-She did not work in t	•					
		g for both houses up until a					
	month ago.	visitors to come to the					
	facility.	VISILOIS to come to me					
	•	ne took clients cell phones					
	away during commun	nity meetings.					
		were using their phones					
	during meetings.	10					
	 -Admitted she attended participant and not state 						
		ents could use phones in the					
	meetings.	5110 COULT GOO P					
	Interview on 10/17/19	with the					
		ed Professional revealed:					
	-The administrative stacility.	taff worked at the women's					
	-	taff did not work at the					
	-There was no report						
	administrative staff ha	ad visitors over the house.					
	-Clients cell phone us	•					
		nined by the facilitator.					
	-Facility staff whether	r participant or transport staff					

Division of Health Service Regulation

meetings.

should not implement facility rules in community

-Staff allowed to take clients phones away if

STATE FORM 545B11 If continuation sheet 5 of 8

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING:	ONSTRUCTION		E SURVEY PLETED	
		MHL076-007	B. WING		10	R 0/ 18/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	E, ZIP CODE		
MANGUM	HOUSE	841 EAS	T PRITCHARD STI	REET		
MANGUM	HOUSE	ASHEBO	PRO, NC 27203			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
V 110	Continued From page	e 5	V 110			
	house rules were bro	ken but not during meetings.				
V 290	27G .5602 Supervise	d Living - Staff	V 290			
	of this Rule shall be denable staff to responneeds. (b) A minimum of one present at all times we premises, except whe habilitation plan docucapable of remaining without supervision. as needed but not less the client continues to the home or commun specified periods of ti (c) Staff shall be presentled or adolescent clients or adolescent clients present. How present during sleeping emergency back-up put the governing body; (2) children or addevelopmental disabi	above the minimum Paragraphs (b), (c) and (d) letermined by the facility to ad to individualized client e staff member shall be hen any adult client is on the en the client's treatment or ments that the client is in the home or community The plan shall be reviewed is than annually to ensure to be capable of remaining in ity without supervision for me. Sent in a facility in the action when more than one ient is present: adolescents with substance be served with a minimum or every five or fewer minor rever, only one staff need be any hours if specified by the procedures determined by or adolescents with lities shall be served with				
	(2) children or a developmental disabi one staff present for present and two staff	adolescents with lities shall be served with every one to three clients present for every four or However, only one staff				

Division of Health Service Regulation

STATE FORM 6899 545B11 If continuation sheet 6 of 8

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
					R	
MHL076-007		B. WING		10/18/2019		
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
MANGUM	HOUSE	841 EAST	PRITCHARD S	TREET		
		ASHEBOR	O, NC 27203			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
V 290	Continued From page	e 6	V 290			
	determined by the go (d) In facilities which diagnosis is substance (1) at least one duty shall be trained i withdrawal symptoms secondary complication drug addiction; and	serve clients whose primary se abuse dependency: e staff member who is on in alcohol and other drug s and symptoms of ons to alcohol and other s of a certified substance Il be available on an				
	This Rule is not met as evidenced by: Based on record review and interview, the facility failed to assess and document client's capability of having unsupervised time in the community and home in the treatment or habilitation plan affecting two of three audited clients (#1, #6 and #7). The findings are: Review on 10/17/19 of client #1's record revealed: -Admission date of 11/20/18Diagnoses of Alcohol Use Disorder, Severe and Cannabis Use DisorderTreatment Plan dated 11/27/18There was no unsupervised time assessment for home and community in the record. Review on 10/17/19 of client #6's record revealed: -Admission date of 5/14/19Diagnoses of Alcohol Use Disorder, Severe, Cannabis Use Disorder, Severe and Unspecified					

Division of Health Service Regulation

-Treatment Plan dated 5/20/19.

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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
MHL076-007			B. WING		R 10/18/2019
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
MANGUM	HOUSE		PRITCHARD S RO, NC 27203	TREET	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
V 290	home and community Review on 10/17/19 or revealed: -Admission date of 7/3-Diagnoses of Alcohor Disorder and General -Treatment Plan dated -There was no unsuphome and community Interview on 10/17/19 Administrator/Qualifier -For the first day's clients unsupervised timeClients not allowed to supervisionClients received pass without supervisionShe was responsible assessments for unsupervision assessments for unsupervision assessments for unsupervision.	ervised time assessment for in the record. If client #7's record 30/19. I Dependence, Depressive ized Anxiety Disorder. d 9/30/19. ervised time assessment for in the record. with the d Professional revealed: ents were not allowed to stay in the facility without ses to leave the facility for completing	V 290	DEFICIENCY)	

Division of Health Service Regulation

STATE FORM 6899 545B11 If continuation sheet 8 of 8