Division of Health Service Regulation

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL096-078	B. WING		11/20/2019	
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE	•	
PINEVIE	W		TH PINEVIEW ORO, NC 27			
(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 000	INITIAL COMMENT	-S	V 000			
	20, 2019. Deficient This facility is licens category: 10A NCA	ras completed on November cies were cited. sed for the following service at 27G .5600C, Supervised h Developmental Disabilities.				
V 114	27G .0207 Emergency Plans and Supplies 10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES (a) A written fire plan for each facility and area-wide disaster plan shall be developed and shall be approved by the appropriate local authority. (b) The plan shall be made available to all staff and evacuation procedures and routes shall be posted in the facility. (c) Fire and disaster drills in a 24-hour facility shall be held at least quarterly and shall be repeated for each shift. Drills shall be conducted under conditions that simulate fire emergencies. (d) Each facility shall have basic first aid supplies accessible for use.		V 114			
	facility failed to ensiquarterly and repeating findings are: During interview on Developmental Carshifts: 1st 8:00 am	et as evidenced by: views and interviews the ure disaster drills were held ted on each shift. The 11/14/19 the Director of e stated the facility had three - 4:00 pm, 2nd 4:00 pm - I 3rd 12:00 midnight - 8:00				

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

TITLE (X6) DATE

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		` '	(3) DATE SURVEY COMPLETED	
		MHL096-078	B. WING		11/2	0/2019	
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
PINEVIE	N		TH PINEVIEV DRO, NC 27				
(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 SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE	
V 114	Continued From pa	ge 1	V 114				
	- Disaster drills inclithreat, violence in the medical emergency - Staff documented what to do in the exituations as listed - No disaster drill exituation	discussion with clients about vent of specific emergency above. Exercises documented for 1st, ring the third quarter (July - or the first quarter (January - 11/14/19 client #5 stated were held "we sit down and n't run down to the basement					
V 290	27G .5602 Supervis	sed Living - Staff	V 290				
	numbers specified of this Rule shall be enable staff to resp needs. (b) A minimum of opresent at all times premises, except whabilitation plan documents.	STAFF os above the minimum in Paragraphs (b), (c) and (d) de determined by the facility to ond to individualized client one staff member shall be when any adult client is on the when the client's treatment or cuments that the client is ong in the home or community					

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				ATE SURVEY OMPLETED	
		MHL096-078	B. WING		11/2	0/2019	
		DRESS, CITY, S	STATE, ZIP CODE	=	<u> </u>		
PINEVIE	w		H PINEVIEW				
			ORO, NC 27		211		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION DEFICIENCY)	D BE	(X5) COMPLETE DATE	
V 290	Continued From pa	ge 2	V 290				
	without supervision as needed but not let the client continues the home or comme specified periods of (c) Staff shall be profollowing client-staff child or adolescent (1) children or abuse disorders short of one staff present clients present. However, the governing body (2) children or developmental disation one staff present for present and two staff present duspecified by the empresent du	The plan shall be reviewed ess than annually to ensure to be capable of remaining in unity without supervision for time. The sesent in a facility in the fratios when more than one client is present: The adolescents with substance all be served with a minimum for every five or fewer minor owever, only one staff need be ping hours if specified by the procedures determined by for adolescents with bilities shall be served with the every one to three clients off present for every four or the serve clients whose primary included by the serve clients with					
		et as evidenced by: views and interviews the ure a client's treatment or					

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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		MHL096-078	B. WING		11/2	0/2019
NAME OF PROVIDER OR SUPPLIER STREET ADD			DRESS, CITY, S	STATE, ZIP CODE		
PINEVIE	w		H PINEVIEW			
(VA) ID	STIMMADV STA	TEMENT OF DEFICIENCIES	ORO, NC 27	PROVIDER'S PLAN OF CORRECTION	- N	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROL DEFICIENCY)	D BE	(X5) COMPLETE DATE
V 290	Continued From pa	ge 3	V 290			
	habilitation plan documented the client was capable of remaining in the community for specified periods of time affecting 2 of 3 audited clients (#2 and #5). The findings are:					
	34 year old male aDiagnoses includeTraumatic Brain Inj	ed Intracranial injury, ury. ated 4/1/19 with no goals or				
	During interview on 11/14/19 client #2 state he could be without staff supervision for 30 - 40 minutes each day. He liked to use his unsupervised time to go for a walk around the block. He felt safe in the neighborhood.					
	 - 66 year old male a - Diagnoses include Korsakoff's Syndron Hepatitis C. - Treatment plan ef 	o of client #5's record revealed: admitted 8/26/13. ed Traumatic Brain Injury, me, Alcoholism, Diabetes, and fective 10/5/19 with no goals supervised time in the				
	could go for a walk "signed out;" he co	11/14/19 client #5 stated he around his neighborhood if he uld be away from the facility round 1/2 hour." The safe.				
	stated clients #2 an	11/14/19 the House Lead d #5 could go for walks thout staff supervision if they ey left the facility.				
	During interview on	11/14/19 the Director of				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE COMF	(X3) DATE SURVEY COMPLETED	
		MHL096-078	B. WING		11/20/2019	
PINEVIEW 304 SOUT			DRESS, CITY, S H PINEVIEV DRO, NC 27			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
V 290	Developmental Car elopement attempts During interview on she understood the time to be included plan. She would ha speak with the Care	e stated there had been no s at the facility. 11/20/19 the President stated requirement for unsupervised in the treatment or habilitation ave the Qualified Professional e Coordinators for clients #2 ng their treatment plans to	V 290			

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