	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED
			A. BUILDING:			
		MHL0411171	B. WING		12/04/2019	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
FRISTON	N DRIVE AFL		ISTON DRIVE BORO, NC 27	7407		
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5) COMPLET
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	DATE
V 000	INITIAL COMMEN	rs	V 000			
		,				
	This facility is licens category:	sed for the following service				
	- 10A NCAC 27 for Alternative Fam	G .5600F: Supervised Living ily Living				
V 110	27G .0204 Training Paraprofessionals	/Supervision	V 110			
	 SUPERVISION OF (a) There shall be paraprofessionals. (b) Paraprofession associate profession professional as spe Subchapter. (c) Paraprofession knowledge, skills a population served. (d) At such time as 	204 COMPETENCIES AND PARAPROFESSIONALS no privileging requirements for hals shall be supervised by an onal or by a qualified ecified in Rule .0104 of this als shall demonstrate and abilities required by the s a competency-based n is established by rulemaking				
	then qualified profe professionals shall	essionals and associate demonstrate competence. hall be demonstrated by s including: ledge; less; ; g; kills;				

TATEMEN	of Health Service Re IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
			A. BUILDING:			
		MHL0411171	B. WING		12/04/2019	
NAME OF PROVIDER OR SUPPLIER STREET			DRESS, CITY, S	TATE, ZIP CODE		
RISTON	I DRIVE AFL		STON DRIVE BORO, NC 27	7407		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLE DATE
V 110	Continued From pa	age 1	V 110			
	develop and impler for the initiation of t	body for each facility shall ment policies and procedures the individualized supervision ich paraprofessional.				
	Based on interview facility Director, fail	et as evidenced by: and record review, one of one ed to demonstrate the r ability required by the				
	revealed he was: - admitted 12-2 - 73 years old - diagnosed wit - Psychotic Specified - Asperger - Major De - Moderate - assessment of - good mer - good pers - can roll hi - can stand	th: c Disorder, Not Otherwise ' s Syndrome pressive Disorder e Intellectual Disability dated 12-20-18 indicated: mory				
aion of LL	Interview on 12-3-1 ealth Service Regulation	9 with client #1 revealed:				

STATE FORM

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED
			A. BOILDING.			
		MHL0411171	B. WING		12/	04/2019
NAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, S	TATE, ZIP CODE		
FRISTON	N DRIVE AFL		ISTON DRIVE SBORO, NC 27	7407		
(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 (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 110	Continued From pa	age 2	V 110			
	 when asked if replied, "Yes he is" reported the I reported the I shower and in the I more often bas in the shower "I ' d rather has when asked if 	rector got along, "good" f the Director was helpful Director bathed him Director bathed him in the				
	Administrator revea - staff at the da came to the progra - "I think it ' s a addressed" - "[client #1] lov can make his need - "I didn ' t wan or anybody to get ir - "Overall the is they (the group hor could chew ' ."	ay program noticed client #1 m with an odor hygiene area that needs to be ves it at (his group) home he is known." t this to be a formal complaint, n trouble." asue has improved, I just think me) ' bit off more than they getting older and his medical	3			
	Coordinator reveale - since client # program in May, 20 ' concerns about c - in August of 2 client #1	9 with client #1 ' s Care ed: 1 was admitted to the day 019 they have had ' on and off lient #1 ' s hygiene 2019 there were no sores on e day program staff were				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED
			A. BOILDING.	······		
		MHL0411171	B. WING		12/04/2019	
NAME OF PROVIDER OR SUPPLIER STREET A			DDRESS, CITY, S	TATE, ZIP CODE		
TRISTON	N DRIVE AFL		STON DRIVE	7407		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLET DATE
V 110	Continued From pa	age 3	V 110			
	the Care Coordinat - on 9-26-19 th noticed pressure ty - on 11-12-19, - on 11-21-19 s	n odor around client #1, but tor did not smell it le nurse from the day program ype sores that were healing the sores were still visible she visited the home and noted d sores on client #1 that were				
	program staff to co activities and issue revealed: - from 9-26-19 notes written - all but one no - "no conce - "good day - "meals ea - restroom - a note on 10-	у"				
	revealed: - client #1 has a shower - client #1 sees management, and medication for anxi - despite client anxiety, he was no prior to giving clien - we still do a s prefers a sponge b - we have a ho the shower	#1 having a prn medication for t administering the medication t #1 a shower shower sometimes, but he				

STATE FORM

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		MHL0411171	B. WING	· · · · · · · · · · · · · · · · · · ·	12/	04/2019
NAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, S ⁻ STON DRIVE	TATE, ZIP CODE		
RISTON	I DRIVE AFL		BORO, NC 27	7407		
(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 (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 110	Continued From pa	age 4	V 110			
	pressure type sore - he had taken physician - he had taken center - the wound ca different type of cus wheelchair, so that - the doctors al	nded quickly to client #1 's				
	Professional reveal - she visits the - she, "just pop on weekends - the facility Dir #1 was admitted - client #1 need clean clothes are p	9 with the Qualified led: facility at least twice a month is in" at night, in the morning or ector was trained when client ds to be completely dry before ut on him every day. ctor] uses powder" on client				
V 111		nent/Habilitation Plan	V 111			
	10A NCAC 27G .02 TREATMENT/HAB	205 ASSESSMENT AND ILITATION OR SERVICE				

of Health Service R	egulation				
NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE COMP	SURVEY LETED
	MHL0411171	B. WING		12/0	4/2019
PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
N DRIVE AFL					
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL	DBE	(X5) COMPLETE DATE
PLAN (a) An assessment client, according to the delivery of serve be limited to: (1) the client's presect (2) the client's need (3) a provisional of established diagno of admission, exced detoxification or oth shall have an estable admission; (4) a pertinent soce and (5) evaluations or psychiatric, substativo vocational, as apprised (b) When services establishment and treatment/habilitation referred to as the "	t shall be completed for a governing body policy, prior to ices, and shall include, but not senting problem; eds and strengths; r admitting diagnosis with an sis determined within 30 days pt that a client admitted to a ner 24-hour medical program olished diagnosis upon ial, family, and medical history; assessments, such as nce abuse, medical, and opriate to the client's needs. are provided prior to the implementation of the on or service plan, hereafter plan," strategies to address the	V 111			
Based on interview staff failed to condu- and evaluations or appropriate to the of #1) of one client su The findings are:	and record review, the facility uct a pertinent medical history; medical assessment as client 's needs, for one (client				
	PROVIDER OR SUPPLIER SUMMARY ST/ (EACH DEFICIENCIES REGULATORY OR L Continued From pa PLAN (a) An assessmen client, according to the delivery of serv be limited to: (1) the client's pre: (2) the client's pre: (3) a provisional o established diagno of admission, exce detoxification or otl shall have an estate admission; (4) a pertinent soce and (5) evaluations or psychiatric, substate vocational, as appr (b) When services establishment and treatment/habilitation referred to as the " client's presenting This Rule is not m Based on interview staff failed to conduct and evaluations or appropriate to the of #1) of one client su	OF CORRECTION IDENTIFICATION NUMBER: MHL0411171 MHL0411171 PROVIDER OR SUPPLIER STREET AD A 201 TRIS GREENSI SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 5 PLAN (a) An assessment shall be completed for a client, according to governing body policy, prior to the delivery of services, and shall include, but not be limited to: (1) the client's presenting problem; (2) the client's needs and strengths; (3) a provisional or admitting diagnosis with an established diagnosis determined within 30 days of admission, except that a client admitted to a detoxification or other 24-hour medical program shall have an established diagnosis upon admission; (4) a pertinent social, family, and medical history; and (5) evaluations or assessments, such as psychiatric, substance abuse, medical, and vocational, as appropriate to the client's needs. (b) When services are provided prior to the establishment and implementation of the treatment/habilitation or service plan, hereafter referred to as the "plan," strategies to address the client's presenting problem shall be documented. This Rule is not met as evidenced by: Based on interview and record review, the facility staff failed to conduct a pertinent medical history; and evaluations or medical assessment as appropriate to the client 's needs, for one (client #1) of one client surveyed. The findings are:	AT OF DEFICIENCIES OF CORRECTION (X1) PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER: (X2) MULTIPL A. BUILDING: MHL0411171 B. WING	TO P DEFICIENCIES OF CORRECTION (X1) PROVIDERSUPPLIERCLA IDENTIFICATION NUMBER: (A2) MULTIPLE CONSTRUCTION A BUILDING: MHL0411171 B. WING PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE NDRIVE AFL A201 TRISTON DRIVE GREENESDRO, NC 27407 SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTIONS NUMBER) ID PREFIX TAG Continued From page 5 V 111 PLAN (a) An assessment shall be completed for a client. according to governing body polycy, prior to the delivery of services, and shall include, but not be limited to: V 111 (2) a provisional or admitting diagnosis with an established diagnosis determined within 30 days of admission, except that a client admitted to a detoxification or other 24-hour medical program shall have an established diagnosis upon admission; V 111 (4) a pertinent social, family, and medical history; and (5) evaluations or assessments, such as psychiatric, substance abuse, medical, and vocational, as appropriate to the client's needs. (b) When services are provided prior to the establishment and implementation of the treatment/habilitation or service plan, hereafter referred to as the "plan," strategies to address the client's presenting problem shall be documented. This Rule is not met as evidenced by: Based on interview and record review, the facility staff failed to the client's needs, for one (client #1) of one client surveyed. The findings are: Definitis needs, for one (client #1) of one client surveyed. <td>OF DEFICIENCIES OF CORRECTION (X1) PROVIDERSUPPLIER IDENTIFICATION NUMBER MHL0411171 (X2) MULTIPLE CONSTRUCTION A BUILDING: (X3) DATE CORRECTION PROVIDER OR SUPPLIER STREET ADDRESS, CITV, STATE, ZIP CODE 1200 PROVIDER OR SUPPLIER STREET ADDRESS, CITV, STATE, ZIP CODE 1200 VDRIVE AFL 4201 TRISTON DRIVE GREENSBORO, NC 27407 PROVIDERS PLAN OF CORRECTION FREQULATORY OR LSC IDENTIFYING INFORMATION) PD PROVIDERS PLAN OF CORRECTION FREQULATORY OR LSC IDENTIFYING INFORMATION) PD PT TAG PROVIDERS PLAN OF CORRECTION FREQULATORY OR LSC IDENTIFYING INFORMATION) PD PT TAG PROVIDERS PLAN OF CORRECTION FREQULATORY OR LSC IDENTIFYING INFORMATION) PD PT TAG PROVIDERS PLAN OF CORRECTION FREQULATORY OR LSC IDENTIFYING INFORMATION) PD PT TAG PROVIDERS PLAN OF CORRECTION FREQULATORY OR LSC IDENTIFYING INFORMATION) PD PT TAG PD CRONTORECTOR ACTION PROVID BE CROSS REFERENCED TO THE APPROPRIATE DEFICIENCY Continued From page 5 V 111 V111 V111 Continued From page 5 V 111 V111 Continue for services, and shall include, but not be devisited diagnosis upon admission; (4) a pertinent social, family, and medical history; and vocational, as app</td>	OF DEFICIENCIES OF CORRECTION (X1) PROVIDERSUPPLIER IDENTIFICATION NUMBER MHL0411171 (X2) MULTIPLE CONSTRUCTION A BUILDING: (X3) DATE CORRECTION PROVIDER OR SUPPLIER STREET ADDRESS, CITV, STATE, ZIP CODE 1200 PROVIDER OR SUPPLIER STREET ADDRESS, CITV, STATE, ZIP CODE 1200 VDRIVE AFL 4201 TRISTON DRIVE GREENSBORO, NC 27407 PROVIDERS PLAN OF CORRECTION FREQULATORY OR LSC IDENTIFYING INFORMATION) PD PROVIDERS PLAN OF CORRECTION FREQULATORY OR LSC IDENTIFYING INFORMATION) PD PT TAG PROVIDERS PLAN OF CORRECTION FREQULATORY OR LSC IDENTIFYING INFORMATION) PD PT TAG PROVIDERS PLAN OF CORRECTION FREQULATORY OR LSC IDENTIFYING INFORMATION) PD PT TAG PROVIDERS PLAN OF CORRECTION FREQULATORY OR LSC IDENTIFYING INFORMATION) PD PT TAG PROVIDERS PLAN OF CORRECTION FREQULATORY OR LSC IDENTIFYING INFORMATION) PD PT TAG PD CRONTORECTOR ACTION PROVID BE CROSS REFERENCED TO THE APPROPRIATE DEFICIENCY Continued From page 5 V 111 V111 V111 Continued From page 5 V 111 V111 Continue for services, and shall include, but not be devisited diagnosis upon admission; (4) a pertinent social, family, and medical history; and vocational, as app

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
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	MHL0411171				12/	04/2019
NAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, S [.] I STON DRIVE	TATE, ZIP CODE		
FRISTON	N DRIVE AFL		BORO, NC 27	7407		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	THE APPROPRIATE	COMPLET DATE
V 111	Continued From pa	age 6	V 111			
	revealed he was: - admitted 12-2 - 73 years old - diagnosed wit - Psychotic Specified - Asperger - Major De - Moderate - assessment of - good mer - good mer - good pers - can roll hi - can stand - can stand - can trans and shower chair - no current ass medical needs rela - inability to from his wheelchai - need for a client in and out of - use of prr	th: c Disorder, Not Otherwise ' s Syndrome pressive Disorder e Intellectual Disability dated 12-20-18 indicated: mory sonality imself in wheelchair d but only briefly fer self from wheelchair to bed sessment indicating additional ited to client #1 ' s: o independently transfer to and r assistive devices for lifting his bed assistive devices for lifting the shower n medications for decreasing r, prior to anxiety-producing				
	revealed: - when client # more mobile than h - he is very any wheelchair	kious about being out of his				
ision of H		nt might be completed is treatment team meeting to				

STATE FORM

FICIENCIES RECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			E SURVEY PLETED
MHL0411171		B. WING		12/	04/2019
R OR SUPPLIER			TATE, ZIP CODE		
AFL			7407		
ACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
ued From pa	ge 7	V 111			
here was no sment of clier ure sores client #1 was and the wou ent of his pre I think it 's go ation as you y around -ins	comprehensive medical ht #1, after he began having taken to his primary care nd care center for the acute essure-like sores bod to have as much can have, it 's just better all stead of running around here				
ee/Administr reatment tea lly each client ' s red annually annual review - medical n - adaptive e - basic care	ator revealed: m meetings are held at least Individual Service Plan is s focus on areas such as: eeds equipment e needs				
CAC 27G .02 lient record s ual admitted n, but need n identification me (last, first ent record nu te of birth; ce, gender ar mission date charge date;	206 CLIENT RECORDS shall be maintained for each to the facility, which shall ot be limited to: face sheet which includes: , middle, maiden); mber; ad marital status;	V 113			
	R OR SUPPLIER AFL SUMMARY STA ACH DEFICIENCY GULATORY OR L nued From parts a his treatment here was no - sment of clier ure sores client #1 was and the wou ent of his pre- I think it 's gr ation as you ay around -ins s a pop quiz ew on 12-3-1 see/Administre reatment tear ly each client 's ved annually annual review - medical n - adaptive e client #1 had n 2006 Client R CAC 27G .02 client record so ual admitted n, but need n identification me (last, first ent record nu te of birth; ce, gender ar	RECTION IDENTIFICATION NUMBER: MHL0411171 MHL0411171 R OR SUPPLIER STREET AI AFL 4201 TRI GREENS SUMMARY STATEMENT OF DEFICIENCIES ACH DEFICIENCY MUST BE PRECEDED BY FULL GULATORY OR LSC IDENTIFYING INFORMATION) Aued From page 7 e his treatment plan here was no comprehensive medical sment of client #1, after he began having ure sores client #1 was taken to his primary care of the wound care center for the acute teent of his pressure-like sores I think it 's good to have as much ation as you can have, it 's just better all ay around -instead of running around here s a pop quiz (and not fully knowing what to eew on 12-3-19 with the see/Administrator revealed: reatment team meetings are held at least lly annual reviews focus on areas such as: - medical needs - adaptive equipment - basic care needs CAC 27G .0206 CLIENT RECORDS slient #1 had not been reviewed recently 0206 Client Records CAC 27G .0206 CLIENT RECORDS slient record shall be maintained for each ual admitted to the facility, which shall n, but need not be limited to: identification face sheet which includes: me (last, first, middle, maiden); ent record number; te of birth; ce, gender and marital status; mission date; charge date;	IDENTIFICATION NUMBER: A. BUILDING: MHL0411171 B. WING R OR SUPPLIER STREET ADDRESS, CITY, S SUMMARY STATEMENT OF DEFICIENCIES 4201 TRISTON DRIVE GREENSBORO, NC 23 SUMMARY STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCIES ID SUMMARY STATEMENT OF DEFICIENCIES ID GREENSBORO, NC 23 SUMMARY STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCIES ID SUMMARY STATEMENT OF DEFICIENCIES ID GREENSBORO, NC 23 SUMMARY STATEMENT OF DEFICIENCIES Guidation State St	ABUILDING:	Rection Dentification NUMBER: A BULDING: 12/ A BULDING: B. WING 12/ R OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE AFL GRESUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE PROVIDER'S PLAN OF CORRECTION (EACH DEPICIENCY MUST BE PRECEDED BY FULL SULATORY OR LSC DENTIFYING INFORMATION) D PREFIX PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE SULATORY OR LSC DENTIFYING INFORMATION) Urde From page 7 V V 111 PREFIX a bit treatment plan here was no comprehensive medical sment of client #1, after he began having res sores V V111 ew on 12-3-19 with the ese/Administrator revealed: reatment team meetings are held at least Ity act olient *s Individual Service Plan is eed annually unanual reviews focus on areas such as: - medical needs - adaptive equipment - basic care needs silent #1 had not been reviewed recently V 2026 Client Records V V V113 CAC 27G .0206 CLENT RECORDS silent fit had not be facility, which shall n, but need not be limited to: identification face sheet which includes: me (last, first, middle, maiden); ant record number; te of birth; ze, gender and marital status; mission date; charge date; V 113

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
			A. DOILDING.			
		MHL0411171	B. WING		12/04/2019	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
RISTO	N DRIVE AFL		STON DRIVE	7407		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T	ION SHOULD BE	(X5) COMPLET DATE
				DEFICIENC	Y)	
V 113		-	V 113			
	diagnosis coded ac (3) documentation of assessment; (4) treatment/habilit (5) emergency infor shall include the na number of the pers sudden illness or ac and telephone num physician; (6) a signed statem responsible person emergency care fro (7) documentation of (8) documentation of (9) if applicable: (A) documentation diagnosis according of Diseases (ICD-9 (B) medication orde (C) orders and copi (D) documentation administration error (b) Each facility sha relative to AIDS or only in accordance disease laws as spo This Rule is not me Based on interview failed to maintain a individual admitted at least; an identific	abilities or substance abuse cording to DSM IV; of the screening and tation or service plan; rmation for each client which ime, address and telephone on to be contacted in case of ccident and the name, address aber of the client's preferred the from the client or legally granting permission to seek om a hospital or physician; of services provided; of progress toward outcomes; of physical disorders g to International Classification -CM); ers; ies of lab tests; and of medication and rs and adverse drug reactions. all ensure that information related conditions is disclosed with the communicable ecified in G.S. 130A-143.				

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			DDRESS, CITY, S	TATE, ZIP CODE		0-1/2010
TRISTON	N DRIVE AFL	4201 TR	ISTON DRIVE BORO, NC 27			
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
V 113	Continued From pa	age 9	V 113			
	for one (client #1) of The findings are:	of one clients surveyed.				
	revealed: - he was admit - he was 73 ye - he was diagn - Psychotic Specified - Asperger - Major De - Moderate	ars old				
	revealed: - there was and administrative offic - files at the ad comprehensive - there was no contained: - legal gua - allergy int - emergend - relevant r - he could see and emergency inf the client files kept - "I think it's g	Iministrative office were face sheet for client #1 which rdian information formation cy telephone numbers medical information the need to have identification ormation readily available in at the facility ood to have as much can have, it 's just better all				
	Interview on 12-4-1 Licensee/Administr - there were ide ealth Service Regulation					

STATE FORM

Division	of Health Service Re	egulation			i orani	
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY LETED
		MHL0411171	B. WING		12/0	4/2019
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
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(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
V 113	each client - these docume located at the admi - "[facility Direc sheets today, this n	ents were in the client files	V 113			
Division of H	ealth Service Regulation					