STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
					F	₹
		MHL098-170	B. WING		01/0	6/2020
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	STATE, ZIP CODE		
WII SON	COUNTY GROUP HO	ME #2 3108 TIL	GHMAN ROA	D		
WILOUIT	OCCITION ON THE	WILSON,	NC 27893			
(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 000	INITIAL COMMENT	rs .	V 000			
		w up survey was completed . A deficiency was cited.				
	category: 10A NCA	sed for the following service C 27G .5600C Supervised h Developmental Disabilities.				
V 290	27G .5602 Supervis	sed Living - Staff	V 290			
	numbers specified in of this Rule shall be enable staff to responeeds.  (b) A minimum of compresent at all times premises, except whabilitation plan doccapable of remaining without supervision as needed but not let the client continues the home or common specified periods of (c) Staff shall be profollowing client-staff child or adolescent (1) children of abuse disorders should of the client spresent. However, the governing slee emergency back-up the governing body (2) children of developmental disa	is above the minimum in Paragraphs (b), (c) and (d) is determined by the facility to cond to individualized client one staff member shall be when any adult client is on the hen the client's treatment or cuments that the client is ing in the home or community. The plan shall be reviewed ess than annually to ensure to be capable of remaining in unity without supervision for time. The plan shall be reviewed essent in a facility in the fratios when more than one client is present:  In a facility in the fration when more than one client is present:  In a facility in the fration when more than one client is present:  In a facility in the fration when more than one client is present:  In a facility in the fration when more than one client is present:  In a facility in the fration when more than one client is present:  In a facility in the fration when more than one client is present:  In a facility in the fration when more than one client is present:  In a facility in the fration when more than one client is present:  In a facility in the fration when more than one client is present:  In a facility in the fration when more than one client is present:  In a facility in the fration when more than one client is present:  In a facility in the fration when more than one client is present:  In a facility in the fration when more than one client is present:  In a facility in the fration when more than one client is present:  In a facility in the fration when more than one client is present:  In a facility in the fration when more than one client is present:  In a facility in the facility in the fration when more than one client is present in a facility in the faci				
	one staff present fo	bilities shall be served with revery one to three clients of present for every four or				

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

(X6) DATE TITLE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
					F	
		MHL098-170	B. WING		01/0	6/2020
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
WILSON	COUNTY GROUP HO	<b>IMF #7</b>	HMAN ROA	D		
0.0.15	CLIMMA DV CTA		NC 27893	DDOVIDEDIC DI ANI OF CODDECTION	ON!	0.45
(X4) ID PREFIX TAG	(EACH DEFICIENC)	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 APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
V 290	more clients present du specified by the em determined by the em diagnosis is substated (1) at least of duty shall be trained withdrawal symptom secondary complicating addiction; and (2) the service	nt. However, only one staff uring sleeping hours if pergency back-up procedures governing body. The serve clients whose primary nice abuse dependency: the staff member who is on the din alcohol and other drug ms and symptoms of actions to alcohol and other drug the serve of a certified substance and be available on an	V 290			
	facility failed to ens habilitation plan do capable of remainir without supervision affecting 2 of 3 aud findings are:	et as evidenced by: views and interviews the ure a client's treatment or cumented the client was ng in the home or community for specified periods of time ited clients (#2 and #5). The				
	- 37 year old male a - Diagnosis of Intell Disability, moderate - "Assessment for to 8/01/19 included storapable of remaining without supervision periods of time Person Centered to "remain safe dur	admitted 8/11/11. ectual/Developmental				

Division of Health Service Regulation

STATE FORM 5899 5UIC11 If continuation sheet 2 of 4

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
			A. BUILDING.	·	F	5	
		MHL098-170	B. WING			6/2020	
NAME OF	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE						
WILSON	COUNTY GROUP HO	)MF #2	GHMAN ROA NC 27893	<b>D</b>			
(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 APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE	
V 290	Continued From pa	ige 2	V 290				
	Client #2 was not a Review on 1/03/20 - 21 year old male a - Diagnoses include Attention Deficit Hy Oppositional Defiar Intellectual Functio - Person Centered documentation of c in the community w periods of time.  Observation on 1/0 am of client #5 reve uniform with a nam grocery store.  During interview on - He was a cashier - He worked up to supervision by facil - He did not have a - He did not have a - He did not have a home or communit - He hoped to leave one situation."  During interview on Manager/Qualified worked at a local g grocery store "watch the facility if he had  During interview on Director stated: - Client #5 worked a cashier and stock	vailable for interview.  of client #5's record revealed: admitted 7/16/18. ed Autism Spectrum Disorder, peractivity Disorder, and Borderline ning. Plan dated 5/01/19 with no lient's capability of remaining without supervision for specified 3/20 at approximately 11:30 ealed him to be dressed, in a e tag, for work at at local  1/03/20 client #5 stated: at a local grocery store. In hours each day with no ity staff. job coach. ny unsupervised time in the					

Division of Health Service Regulation

STATE FORM 5899 5UIC11 If continuation sheet 3 of 4

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
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		MHL098-170	B. WING		01/0	6/2020
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
WILSON	COUNTY GROUP HO	1M F 女ソ	HMAN ROA NC 27893	.D		
(V4) ID	SLIMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTI	ON	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	COMPLETE DATE
V 290	Continued From pa	ge 3	V 290			
V 290	supervised him whi - Grocery store state needed She understood the unsupervised time	le he worked. If knew to contact the facility if the requirement for clients' in the home or community, for If time, to be documented in	V 290			

Division of Health Service Regulation