STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		egulation (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED 01/10/2020	
		MHL092-864				
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
ERRY'S	SAFE HAVEN		NNING CEDA	R TRAIL		
			H, NC 27615	7		1
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLET DATE
V 289	 INITIAL COMMENTS An Annual Survey was completed January 10, 2020. A deficiency was cited. This facility is licensed for the following service category: 10A NCAC 27G .5600F Supervised Living/ Alternate Family Living. 27G .5601 Supervised Living - Scope 10A NCAC 27G .5601 SCOPE (a) Supervised living is a 24-hour facility which provides residential services to individuals in a home environment where the primary purpose of these services is the care, habilitation or 		V 000 V 289	 United Support Services, Inc. aware of the State Licensure F for adult and children not reside in the same licensed facility. There were 3 children living in home since 2015. Previously Child A turned 18 and remained school - a exception request w requested and granted. Child turned 18 in October. It was a oversight of the agency to sub the exception. The 3rd child " will be turning 18 in April of 20 		1/14/20
	rehabilitation of ind illness, a developm or a substance abu supervision when ir (b) A supervised liv the facility serves e (1) one or mo (2) two or mo Minor and adult clie same facility. (c) Each supervise licensed to serve a designated below: (1) "A" design	ividuals who have a mental ental disability or disabilities, use disorder, and who require in the residence. ving facility shall be licensed if ither: ore minor clients; or ore adult clients. ents shall not reside in the ed living facility shall be specific population as nation means a facility which		As of April 2020 all the clie living in the home will be ac USS submitted a plan of protection and request for exception on January 14, 2 DHSR. The exception require will cover until the final chil out in April 2020. This is th licensed home that United Support Services, Inc. has services individuals under the of 18. Once the 3rd client the	dults. 2020 to uest d ages e only that the age urns 18	
	illness but may also (2) "B" design serves minors who developmental disa diagnoses; (3) "C" design serves adults whos developmental disa diagnoses;	e primary diagnosis is mental o have other diagnoses; nation means a facility which se primary diagnosis is a ability but may also have other nation means a facility which e primary diagnosis is a ability but may also have other nation means a facility which		in April of 2020, we will no have any need for exceptic agency wide. Please find t attached plan of protection the request for exception th sent on 1/14/20.	ons - he and	

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

TITLE

(X6) DATE

If continuation sheet 1 of 4

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STATE FORM

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Director

Division of Health Service Reg STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED	
		MHL092-864			01/	01/10/2020
IAME OF F	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, ST	ATE, ZIP CODE		
ERRY'S	SAFE HAVEN		NNING CEDAR I, NC 27615	TRAIL		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
V 289	Continued From pa	ge 1	V 289			
	substance abuse d other diagnoses; (5) "E" design serves adults whos substance abuse d other diagnoses; or (6) "F" design private residence, w three adult clients w mental illness but n disabilities, or three clients whose prima developmental disa other disabilities wh family provides the exempt from the fo .0201 (a)(1),(2),(3), (A),(B),(E),(F),(G),((18) and (b); 10A N (i); 10A NCAC 27G (a),(b); 10A NCAC 10 27G .0208 (b),(e); non-prescription me (1)(A),(D),(E);(f);(g) (b)(2),(d)(4). This f alternative family liv (AFL).	hation means a facility in a which serves no more than whose primary diagnoses is nay also have other e adult clients or three minor ary diagnoses is abilities but may also have no live with a family and the service. This facility shall be llowing rules: 10A NCAC 27G (4),(5)(A)&(B); (6); (7) H); (8); (11); (13); (15); (16); CAC 27G .0202(a),(d),(g)(1) .0203; 10A NCAC 27G .0205 27G .0207 (b),(c); 10A NCAC 10A NCAC 27G .0209[(c)(1) - edications only] (d)(2),(4); (e) b; and 10A NCAC 27G .0304 facility shall also be known as <i>v</i> ing or assisted family living				
	failed to assure mir	view and interview, the facility nor and adults clients resided This affected three of three				
	Deview en 01/00/00) of the facility's public record				

STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED	
		MUI 002 864				
	MHL092-864				01/	10/2020
IAME OF	PROVIDER OR SUPPLIER		DDRESS, CITY, STAT NNING CEDAR T			
ERRY'S	SAFE HAVEN		H, NC 27615			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 289	Continued From page 2		V 289			
	Regulation revealed -Waiver approval le 2016: client (with in approved to reside initials same as clie expired December renewed annually. -No evidence of sul approved for 2018- Review on 01/09/20 revealed: -Admitted: 2015 -Diagnosis: Autism -Age: 18 -Attended high scho Review on 01/09/20 revealed: -Admitted:2013 -Diagnosis: Mild Int Disability (IDD), De Hashimototo Disea -Age: 20	Atter dated November 26, itials same as client #2) was with minors clients (with onts #1 and #3). The approval 2017 and approval must be obsequent waivers submitted o present year of 2020 0 of client #1's record 0 of client #2's record ellectual Developmental	r			
	revealed: -Admitted: 2013 -Diagnosis: Severe -Age: 17					
	reported: -The clients had gro as minors -Clients #1 and #3 utilized community volunteering	10/09/20, the Licensee own up in the facility together were in school and client #2 resources during the day by y was in April 2020 and she				

Division of Health Service Regulation STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
AND PLAN OF CORRECTION		DENTITIOATION NOMBER.	A. BUILDING:		COMPLETED	
		MHL092-864	B. WING		01/	10/2020
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
ERRY'S	SAFE HAVEN		NNING CEDAR H, NC 27615	RTRAIL		
(X4) ID	SUMMARY STA			PROVIDER'S PLAN OF	CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE	COMPLET DATE
V 289	Continued From pa	ge 3	V 289			
	management comp the waiver renewal reside in the same	nterview, she contacted her pany to find out the status of for adult and minor clients to				

ZOZR11