STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL026-639	A. BUILDING: _____ B. WING _____	01/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
C R E S T GROUP HOME #1	1533 MINTZ DRIVE FAYETTEVILLE, NC 28303

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 000	INITIAL COMMENTS An annual survey was completed on January 9, 2020. A deficiency was cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities.	V 000	DHSR - Mental Health FEB 13 2020 Lic. & Cert. Section	
V 112	27G .0205 (C-D) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (c) The plan shall be developed based on the assessment, and in partnership with the client or legally responsible person or both, within 30 days of admission for clients who are expected to receive services beyond 30 days. (d) The plan shall include: (1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement; (2) strategies; (3) staff responsible; (4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both; (5) basis for evaluation or assessment of outcome achievement; and (6) written consent or agreement by the client or responsible party, or a written statement by the provider stating why such consent could not be obtained.	V 112		

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: SRose
TITLE: Director of Residential Ser
(X6) DATE

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V 112	Continued From page 1 This Rule is not met as evidenced by: Based on record reviews, observation and interviews, the facility failed to develop and implement strategies based on assessment affecting one of three audited clients (#1). The findings are: Review on 01/08/20 of client #1's record revealed: - 56 year old male. - Admission date of 11/19/12. - Diagnoses of Severe Mental Retardation, Hypertension and Arthritis. - Person-Center Plan dated 11/30/19. - No strategies to address client #1's use of Continuous Positive Airway Pressure (CPAP) device and associated oxygen. Review on 01/08/20 and 01/09/20 of signed physician orders revealed: 03/29/19 - Oxygen at 2 liters into the CPAP every evening. 07/01/19 - Continue nightly CPAP usage. Observation on 01/08/20 at approximately 9:30am of client #1's bedroom revealed: - A CPAP device on the bedside table next to his bed. - An oxygen concentrator next to the bedside table. Interview on 01/09/20 client #1 stated: - He was unsure of how long he had resided at the facility. - He used his CPAP every night. Interview on 01/08/20 and 01/09/20 the Qualified	V 112		

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V 112	Continued From page 2 Professional stated: - Client #1 used his CPAP at bedtime. - Client #1 had oxygen connected to his CPAP. - She understood the treatment plan needed to contain strategies to address client #1's CPAP usage and the connected oxygen.	V 112	* Upon discovery, QP immediately called the doctors office to get a copy of the prescription verifying O2 levels. * QP also scheduled training for one staff to go and meet with the company that provided the O2, and that one person came back and trained the other staff at Crest. * QP updated the consumers Plan with CPAC and O2 levels making it available to all the staff to see * A schedule has been implemented for cleaning of the CPAC machine 3X weekly and this will be monitored by Cert M. * On going training and monitoring will be conducted by assigned staff and report will be sent to QP * Qualerly review and traing will be conducted by QP to ensure that all equipment are operational and in an effort to prevent futher incidents * CPAC machine & O2 levels will be checked and monitored daily	1/10/2020 1/17/2020 1/20/2020 ongoing ongoing ongoing

NC DEPARTMENT OF
HEALTH AND
HUMAN SERVICES

ROY COOPER • Governor
MANDY COHEN, MD, MPH • Secretary
MARK PAYNE • Director, Division of Health Service Regulation

January 15, 2020

Ms. Denise Rose, Director of Residential Services
Cumberland Residential & Employment Services & Training
P.O. Box 877
Fayetteville, NC 28302

Re: Annual Survey completed January 9, 2020
C.R.E.S.T. Group Home #1, 1533 Mintz Drive, Fayetteville, NC 28303
MHL # 026-639
E-mail Address: drose@crestnc.org; kharney@crestnc.org

Dear Ms. Rose:

Thank you for the cooperation and courtesy extended during the annual survey completed January 9, 2020.

Enclosed you will find all deficiencies cited listed on the Statement of Deficiencies Form. The purpose of the Statement of Deficiencies is to provide you with specific details of the practice that does not comply with state regulations. You must develop one Plan of Correction that addresses each deficiency listed on the State Form, and return it to our office within ten days of receipt of this letter. Below you will find details of the type of deficiencies found, the time frames for compliance plus what to include in the Plan of Correction.

Type of Deficiencies Found

- The tag cited is a standard level deficiency.

Time Frames for Compliance

- A standard level deficiency must be ***corrected*** within 60 days from the exit of the survey, which is March 9, 2020.

What to include in the Plan of Correction

- Indicate what measures will be put in place to ***correct*** the deficient area of practice (i.e. changes in policy and procedure, staff training, changes in staffing patterns, etc.).
- Indicate what measures will be put in place to ***prevent*** the problem from occurring again.
- Indicate ***who will monitor*** the situation to ensure it will not occur again.
- Indicate ***how often*** the monitoring will take place.
- Sign and date the bottom of the first page of the State Form.

Make a copy of the Statement of Deficiencies with the Plan of Correction to retain for your records. ***Please do not include confidential information in your plan of correction and please remember never to send confidential information (protected health information) via email.***

Send the original completed form to our office at the following address within 10 days of receipt of this letter.