	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION			E SURVEY PLETED
		IDENTIFICATION NOWBER.		A. BUILDING:		
		MHL092-958	B. WING			C <b>22/2020</b>
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
DIVINE S	SUPPORTIVE HOMES		RSH CREEK R H, NC 27604	ROAD		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C	ORRECTION	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	HE APPROPRIATE	COMPLET DATE
V 000	INITIAL COMMENT	ſS	V 000			
	The complaint was	A complaint survey was completed on 06-22-20. The complaint was unsubstantiated Intake #NC00165932. Deficiencies were cited.				
	This facility is licensed for the following service category: 10A NCAC 27 G.5600A Supervised Living for Adults with Mental Illness.					
V 132	G.S. 131E-256(G) I Allegations, & Prote		V 132			
	G.S. §131E-256 HEALTH CARE PERSONNEL REGISTRY (g) Health care facilities shall ensure that the					
	Department is notifi health care personr	ied of all allegations against nel, including injuries of				
	any act listed in sub (which includes:	hich appear to be related to odivision (a)(1) of this section.				
	facility or a person t	e of a resident in a healthcare to whom home care services 131E-136 or hospice services				
	as defined by G.S. b. Misappropriatio	131E-201 are being provided. n of the property of a resident				
	(b) of this section in care services as de	ility, as defined in subsection Icluding places where home fined by G.S. 131E-136 or				
	are being provided.	s defined by G.S. 131E-201 n of the property of a				
	healthcare facility. d. Diversion of dru	igs belonging to a health care				
		nt or client. health care facility or against or whom the employee is				
		e evidence that all alleged d and must make every effort				
ision of Li		from harm while the				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		egulation (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	MHL092-958		B. WING			C 22/2020
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
DIVINE S	SUPPORTIVE HOMES		RSH CREEK F I, NC 27604	ROAD		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' 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 132	investigation is in pr investigations must	rogress. The results of all be reported to the ive working days of the initial	V 132			
	failed to notify the H	view and interview the facility lealth Care Personnel ons of abuse for one of one				
	Response Improver there was no level I	of the North Carolina Incident ment System (IRIS) revealed I incident report completed tion of abuse by staff #1.				
	stated: -He had been c Adult Protective Ser -The worker sta investigation regard #1 had "choked" hir					
		vas not aware of the the APS worker arriving to the				
		6/17/20 The Licensee stated: ome one afternoon when an d up to investigate a				

Division of Health Service Regulation STATE FORM

Division of Health Service Re	egulation	-			
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	MHL092-958	B. WING			C 22/2020
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE		
DIVINE SUPPORTIVE HOMES	3905 MAI	RSH CREEK R	OAD		
DIVINE SUPPORTIVE HOMES	RALEIGH	I, NC 27604			
PREFIX (EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	ON SHOULD BE	(X5) COMPLETE DATE
V 132 Continued From pa	ige 2	V 132			
complaint that staff -He cooperated she conducted her with all requested p -He contacted I to inform him of the guidance on movin -The QP told hi included interviewir -The QP told hi investigation. -He stated he in and did not find the -He did not con HCPR of the allega -"I was not awa done." Review on 6/18/20 Licensee dated 5/2 of his interviews with During interview on -The Licensee weeks ago to inforr allegations of abus -Instructed the investigation and do -He also went of and did not occur. -Did not completion	his Qualified Professional (QP) e allegations and request g forward. Im to do an investigation that ng all clients and staff. Im to document the interviewed all clients and staff allegations to be true. Inplete the IRIS report or notify tion. Ire the report needed to be of Fax received from the 9/20 revealed documentation th clients and staff. 6/18/20 The QP stated: had contacted him a few in him of APS out to investigate e regarding staff #1. licensee to complete an ocument it. out and interviewed the clients ed the allegations were false ete IRIS report or notify HCPR. t had to be done since the				

Division	of Health Service Re	aulation			FORM	APPROVED
STATEMEN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		MHL092-958	B. WING		C 06/22/2020	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
	SUPPORTIVE HOMES	3905 MAF	RSH CREEK	ROAD		
		RALEIGH	, NC 27604			
(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 APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
V 364	Continued From pa	ge 3	V 364			
V 364	G.S. 122C- 62 Add Facilities	litional Rights in 24 Hour	V 364			
Division of H	Facilities. (a) In addition to th 122C-51 through G who is receiving treat 24-hour facility keep (1) Send and received access to writing massistance when net (2) Contact and could and at no cost to the physicians, and prived developmental disat professionals of his (3) Contact and could there is a client advector there is a client advector the rights specified restricted by the face exercise these right (b) Except as provided of this section, eacher treatment or habilitat times keeps the right (1) Make and received (2) Receive visitors a.m. and 9:00 p.m. hours daily, two hour p.m.; however visition over the rapies; (3) Communicate as supervision with induced upon the consent of the consent of	ve sealed mail and have aterial, postage, and staff ecessary; nsult with, at his own expense e facility, legal counsel, private vate mental health, bilities, or substance abuse choice; and nsult with a client advocate if ocate. I in this subsection may not be sility and each adult client may is at all reasonable times. ded in subsections (e) and (h) n adult client who is receiving ation in a 24-hour facility at all nt to: ve confidential telephone ice calls shall be paid for by e of making the call or made ing party; s between the hours of 8:00 for a period of at least six urs of which shall be after 6:00 ng shall not take precedence and meet under appropriate ividuals of his own choice				

	of Health Service Re		()(0) 10:		<i></i>	
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED
		MHL092-958	B. WING	_		C 22/2020
	PROVIDER OR SUPPLIER		DRESS, CITY, ST		<b>_</b>	
	FROVIDER OR SUFFLIER		RSH CREEK R			
DIVINE S	SUPPORTIVE HOMES		, NC 27604			
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	THE APPROPRIATE	COMPLET DATE
V 364	Continued From pa	ge 4	V 364			
	unless:					
		oceedings were initiated as				
		nt's being charged with a				
		ling a crime involving an				
	assault with a dead	ly weapon, and the				
	respondent was fou	ind not guilty by reason of				
	insanity or incapable					
		voluntarily admitted or				
		cility while under order of				
		prrectional facility of the				
		rrection of the Department of				
	Public Safety; or	ing hold to dotorming consoity				
	to proceed pursuan	ing held to determine capacity				
		expressly authorize visits				
		d by the existence of the				
		ed by this subdivision;				
	•	daily and have access to				
		nent for physical exercise				
	several times a wee	ek;				
		ibited by law, keep and use				
		nd possessions, unless the				
		to determine capacity to				
	proceed pursuant to					
	(7) Participate in re					
		d a reasonable sum of his				
	own money;	money; Retain a driver's license, unless otherwise				
		er 20 of the General Statutes;				
	and	er zo or the General Statutes,				
		individual storage space for				
	his private use.					
		e rights enumerated in G.S.				
		.S. 122C-57 and G.S.				
		.S. 122C-61, each minor client				
	who is receiving tre	atment or habilitation in a				
		the right to have access to				
	1 14					
		ision and guidance. In inor's status as a developing				

Division of Health Service Regulation     STATEMENT OF DEFICIENCIES   (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING:			PLETED
						С
		MHL092-958	B. WING			22/2020
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, SI	TATE, ZIP CODE		
		3905 MA	RSH CREEK R	ROAD		
	SUPPORTIVE HOMES	RALEIGI	H, NC 27604			
(X4) ID	_		ID	PROVIDER'S PLAN OF		(X5) COMPLET
PREFIX TAG		MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO	THE APPROPRIATE	DATE
				DEFICIENC	CY)	
V 364	Continued From page	ge 5	V 364			
	individual, the minor	r shall be provided				
		ble him to mature physically,				
	emotionally, intellec					
		of the physical, emotional,				
		naturity of the minor, the				
		l provide appropriate				
		on and control consistent with				
		ne minor pursuant to this Part.				
		o, where practical, make				
		o ensure that each minor				
	client receives treat	ment apart and separate from				
		the treatment needs of the				
	minor client dictate	client dictate otherwise.				
	Each minor client w	ho is receiving treatment or				
		4-hour facility has the right to:				
	(1) Communicate a	and consult with his parents or				
	guardian or the age	ncy or individual having legal				
	custody of him;					
	(2) Contact and co	nsult with, at his own expense				
	or that of his legally	responsible person and at no				
	cost to the facility, le	egal counsel, private				
	physicians, private i	mental health, developmental				
	disabilities, or subst	ance abuse professionals, of				
	his or his legally res	ponsible person's choice; and				
	(3) Contact and co	nsult with a client advocate, if				
	there is a client adv	ocate.				
	<b>e</b> .	in this subsection may not be				
		ility and each minor client				
		rights at all reasonable times.				
		ded in subsections (e) and (h)				
	-	n minor client who is receiving				
		ation in a 24-hour facility has				
	the right to:					
		ve telephone calls. All long				
		be paid for by the client at the				
		call or made collect to the				
	receiving party;					
		ve mail and have access to ostage, and staff assistance				

Division	of Health Service Re	gulation				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY PLETED
		MHL092-958	B. WING			C <b>22/2020</b>
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
		3905 MA	RSH CREEK R	OAD		
DIVINE S	SUPPORTIVE HOMES	RALEIG	H, NC 27604			
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	THE APPROPRIATE	COMPLETE DATE
V 364	Continued From pa	ge 6	V 364			
	when necessary;					
		ate supervision, receive				
		e hours of 8:00 a.m. and 9:00				
		at least six hours daily, two				
		l be after 6:00 p.m.; however				
		e precedence over school or				
	therapies;	Loducation and vegetional				
		l education and vocational ice with federal and State law;				
		daily and participate in play,				
		sical exercise on a regular				
	basis in accordance					
		ibited by law, keep and use				
		nd possessions under				
		sion, unless the client is being				
	G.S. 15A-1002;	apacity to proceed pursuant to	)			
	(7) Participate in re					
		individual storage space for personal belongings;				
		and spend a reasonable sum				
	of his own money; a					
		s license, unless otherwise				
		er 20 of the General Statutes.				
		rated in subsections (b) or (d)				
		ection may be limited or restricted except				
		essional responsible for the				
		lient's treatment or habilitation				
		ment shall be placed in the				
		ndicates the detailed reason he restriction shall be				
		ated to the client's treatment of	r l			
		A restriction is effective for a				
		d 30 days. An evaluation of				
		Il be conducted by the				
		al at least every seven days,				
		striction may be removed.				
	Each evaluation of a	a restriction shall be				
		client's record. Restrictions on				

STATEMENT OF DEFICIENCIES (AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		IDENTIFICATION NOMBER.	A. BUILDING:			
		MHL092-958	B. WING			C 22/2020
IAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
	SUPPORTIVE HOMES		RSH CREEK R	OAD		
		RALEIGH	, NC 27604			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' 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 364	Continued From pa	ge 7	V 364			
	statement entered by the client's record the renewal of the restriction of the restriction of the restriction of rig by the client shall, us be notified of the re- it. In the case of a madult client, the lega- be notified of each if or renewal of a restriction of a restriction reason for it. Notific individual or legally	wed only by a written by the qualified professional in nat states the reason for the iction. In the case of an adult been adjudicated incompetent, an initial restriction or renewal ghts, an individual designated upon the consent of the client, striction and of the reason for ninor client or an incompetent ally responsible person shall instance of an initial restriction riction of rights and of the ation of the designated responsible person shall be ng in the client's record.				
		s the facility failed to ensure 1) was able to make phone				
	-He is not allow -His brother/pas	6/17/20 Client #1 stated: ed to call his brother. stor can call him. t let him make phone calls to r when he wants.				
	-Client #1 is allo calls from his brothe call them. -Client #1's mod #1 to call his brothe	6/17/20 Staff #1 stated: bwed to receive telephone er/pastor but not allowed to ther told him to not allow client r/pastor. ct out after he speaks with his				

Division	of Health Service Re	equiation				APPROVED
STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		MHL092-958	B. WING			C 22/2020
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
	SUPPORTIVE HOMES		RSH CREEK F I, NC 27604	ROAD		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C	ORRECTION	(X5)
PRÉFIX TAG		MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	IE APPROPRIATE	COMPLETE DATE
V 364	Continued From pa	ge 8	V 364			
	another state to live -Client #1's gua	brother/pastor because he wants to move to another state to live with his brother. -Client #1's guardian is supposed to speak with the brother and encourage him to stop				
	-All clients can calls. -Client #1 has b from a brother and leave the facility. -After client #1 he exhibits behavio to move with them.	6/17/20 The Licensee stated: make and receive telephone peen receiving phone calls pastor who are suggesting he speaks with his brother/pastor rs as a result of not being able ther had requested they				

STATE FORM

LLSG11

If continuation sheet 9 of 10

T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COM	E SURVEY PLETED
	MUU 000 050			С	
				06/	22/2020
ROVIDER OR SUPPLIER					
UPPORTIVE HOMES			OAD		
		ID			(X5)
		PREFIX TAG	CROSS-REFERENCED TO T	HE APPROPRIATE	COMPLET DATE
Continued From pa	ge 9	V 364			
brother/pastor. -Client #1's lega suggested contactin them know to limit t -Never prohibite	al guardian had also ng the brother/pastor to let heir contact or not at all. ed client #1 from making or				
	T OF DEFICIENCIES DF CORRECTION ROVIDER OR SUPPLIER UPPORTIVE HOMES SUMMARY STA (EACH DEFICIENCY REGULATORY OR LE Continued From pa prohibit client #1 fro brother/pastor. -Client #1's legs suggested contactin them know to limit t -Never prohibit	OF CORRECTION IDENTIFICATION NUMBER:   MHL092-958 MHL092-958   ROVIDER OR SUPPLIER STREET A   UPPORTIVE HOMES 3905 MA   RALEIG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   Continued From page 9 prohibit client #1 from speaking with his	T OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE   DENTIFICATION NUMBER: A. BUILDING:   MHL092-958 B. WING   ROVIDER OR SUPPLIER STREET ADDRESS, CITY, ST   UPPORTIVE HOMES 3905 MARSH CREEK R   SUMMARY STATEMENT OF DEFICIENCIES ID   (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX   REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX   TAG V 364   Prohibit client #1 from speaking with his V 364   prohibit client #1 from speaking with his V 364   suggested contacting the brother/pastor to let them know to limit their contact or not at all.   -Never prohibited client #1 from making or NU 364	T OF DEFICIENCIES DF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING:	T OF DEFICIENCIES DF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING: