STATEMENT OF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA         AND PLAN OF CORRECTION       IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED C		
AME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, ST NCES DRIVE	TATE, ZIP CODE		
RADLE	Y HOME EXTENSION	I-PKEDS HOUSE	R, NC 27529			
(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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLE DATE
V 000	INITIAL COMMEN	TS	V 000			
	The complaint was	was completed on 10/26/20. unsubstantiated (Intake 0170561)). Deficiencies were				
		sed for the following service C 27G.5600A Supervised th Mental Illness.				
V 112	27G .0205 (C-D) Assessment/Treatr	nent/Habilitation Plan	V 112			
	PLAN (c) The plan shall I assessment, and ir legally responsible of admission for cli receive services be (d) The plan shall (1) client outcome achieved by provisi projected date of a (2) strategies; (3) staff responsib (4) a schedule for annually in consulta responsible person (5) basis for evalua outcome achievem (6) written consent	ILITATION OR SERVICE be developed based on the in partnership with the client or person or both, within 30 days ents who are expected to eyond 30 days. include: (s) that are anticipated to be on of the service and a chievement; le; review of the plan at least ation with the client or legally or both; ation or assessment of				
		y such consent could not be				

Division of Health Service Regulation STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL092610			CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			A. BUILDING:			С
		B. WING			26/2020	
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	ATE, ZIP CODE		
BRADLE	EY HOME EXTENSION	-PKEDS HOUSE	NCES DRIVE R, NC 27529			
(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 1 DEFICIENC	THE APPROPRIATE	COMPLET DATE
V 112	Continued From pa	ge 1	V 112			
	This Rule is not me	et as evidenced by:				
	Based on record re interviews, the facili were developed and audited client (#4) a	view, observation and ity failed to ensure strategies d implemented for one of one and have a current treatment e of four audited clients (#2).				
	revealed: -Admission date 6/2	20 of client #4's record 14/2002 ohrenia and Nicotine				
	revealed: -Treatment Plan da -No updated strateg in smoking to 4 in th	0/7/20 of client #4's record ted 5/1/20 gies to address the decrease ne morning and 4 in the				
	-She will cut back for reducing cigarette s -Qualified Profession	garette smoking gradually rom smoking a pack a day by smoking during the day to 5 onal (QP) and facility staff will rage her to decrease her				
	-Been in facility 17 -She needed to qui -She brought her ov	t smoking wn cigarettes arettes in the morning and 4 in				

Division	of Health Service Re	aulation			FORM	APPROVED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		MHL092610	B. WING			26/2020
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
	Y HOME EXTENSION	907 FRAM	NCES DRIVE			
DRADLE		GARNER	, NC 27529			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	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 112	Continued From pa	ge 2	V 112			
	During interview on -She had worked at -She came in every -Client #4 smokes 4 4 in the evening -The cigarettes and kitchen counter by t -Client #4 will leave if she doesn't have During interview on reported: -She is at the facilit -Client #4 coughed -Client #4 coughed -Client #4's smokin cigarettes -This was not in clie -The limitations on discussion within th -Will speak with the #4's treatment plan During interview on -She went to the fac -She was responsite plans -Client #4 could sm -Client #4 will leave any cigarettes to go -Licensee wanted to not sure what she f facility -She never wrote a about decreasing c -Licensee told her to treatment plan yest -Planned to go by th meet with client #4	10/5/20 staff #1 reported: the facility for about a year morning for about 3-4 hours d cigarettes in the morning and lighter always stay on the the back door the premise to get cigarettes any available to her 10/5/20 the Licensee y daily a lot when she smoked g has been limited to 4 ent #4's treatment plan the cigarettes was a the facility with staff e QP about adding it in client 10/7/20 the QP reported: cility 3-4 times per week ble for writing the treatment toke in the facility the facility if she doesn't have o reduce her smoking but is nas already put in place in the nything in the treatment plan lient #4's smoking hat she needed to add it to the				
Division of U		/20 OF CHEFTL #2 S FECOLO				
	ealth Service Regulation					

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If continuation sheet 3 of 6

Nivision of Health Service Regulation           TATEMENT OF DEFICIENCIES         (X1) PROVIDER/SUPPLIER/CLI.           ND PLAN OF CORRECTION         IDENTIFICATION NUMBER		· ,	CONSTRUCTION		E SURVEY PLETED	
		A. BUILDING:		C		
MHL092610		B. WING			10/26/2020	
PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, S <sup>-</sup>	TATE, ZIP CODE			
Y HOME EXTENSION	J-PKEDS HOUSE	-				
(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO	FION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE	
Continued From pa	age 3	V 112				
-Diagnoses of Hyp Disability, Bipolar M Hyperlipidemia. -No current Treatm During interview or -Had not seen any while. -Was trained on the over a year ago.	pertension, Intellectual Mood Disorder and Nent Plan present. In 10/21/20 Staff #1 stated: treatment plans for clients in a em when she started working					
-Staff #1 looking th for client #2's treate -Staff #1 pulled mu	rough multiple folders looking ment plan. Itiple treatment plans dated					
stated: -Clients current treat the facility.	atment plans are all present ir					
27G .0303(c) Facili	ity and Grounds Maintenance	V 736				
EXTERIOR REQU (c) Each facility and	IREMENTS	y				
	PROVIDER OR SUPPLIER Y HOME EXTENSION SUMMARY ST/ (EACH DEFICIENC) REGULATORY OR L Continued From parevealed: -Admission date of -Diagnoses of Hyp Disability, Bipolar M Hyperlipidemia. -No current Treatm During interview or -Had not seen any while. -Was trained on the over a year ago. -"The clients know on." Observation on 10/ -Staff #1 looking th for client #2's treath -Staff #1 pulled mut from 2017 and 201 correct ones. During interview or stated: -Clients current treath the facility. -The QP completes facility. 27G .0303(c) Facil 10A NCAC 27G .03 EXTERIOR REQU (c) Each facility and	PROVIDER OR SUPPLIER       STREET         Y HOME EXTENSION-PKEDS HOUSE       907 FR/GARNE         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       Image: Continued From page 3         Continued From page 3       revealed:         -Admission date of - Unknown       -Diagnoses of Hypertension, Intellectual Disability, Bipolar Mood Disorder and Hyperlipidemia.         -No current Treatment Plan present.       During interview on 10/21/20 Staff #1 stated:         -Had not seen any treatment plans for clients in while.       -Was trained on them when she started working over a year ago.         -"The clients know what their goals are to work on."       Observation on 10/21/20 at 10:00 AM revealed:         -Staff #1 looking through multiple folders looking for client #2's treatment plan.       -Staff #1 pulled multiple treatment plans dated from 2017 and 2018 asking if these were the correct ones.         During interview on 10/21/20 The Licensee stated:       -Clients current treatment plans are all present in the facility.         -The QP completes them and leaves them in the facility.         27G .0303(c) Facility and Grounds Maintenance         10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS (c) Each facility and its grounds shall be	MHL092610       B. WING	MHL092610     B. WING       PROVIDER OR SUPPLIER     STREET ADDRESS, CITY, STATE, ZIP CODE       907 FRANCES DRIVE GARNER, NC 27529     907 FRANCES DRIVE GARNER, NC 27529       SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)     ID PROVIDER'S PLAN OF (EACH OERRECTVE ACU (EACH OERRECTVE ACU (COSS-REFERENCED TO) (EACH OERRECTVE ACU (COSS-REFERENCED TO) (EACH OERRECTVE ACU (CROSS-REFERENCES) (COTINI US TESTING INTO THE ACU (CROSS-REFERENCES) (COTINI US TESTING INFORMATION)     V 112       V 112     V     112       V 112     V     112       V 112     V     112       V 112     V     112       V 112     V     112       V 112     V     112       V 112     V     112       V 200 Course of Hypertension, Intellectual Disability, Bipolar Mood Disorder and Hypertipidemia.     V       V 201 Course of Hypertension, In	MHL092610         B. WING         10/           ROVIDER OR SUPPLIER         STREET ADDRESS, CITY, STATE, ZIP CODE         907 FRANCES DRIVE GARNER, NC 27529         907 FRANCES DRIVE GARNER, NC 27529         900 preserve and prevention of connections         907 FRANCES DRIVE GARNER, NC 27529         900 preserve and prevention of connections         907 FRANCES DRIVE GARNER, NC 27529         900 preserve and prevention of connections         900 prevention         (EACH ORPECTIVE ACTION SHOULD BE (EACH ORPECTIVE ACTION SHOULD DE CONSE-REFERENCED TO THE APPROPRIATE DEFICIENCY)         900 prevention         (EACH ORPECTIVE ACTION SHOULD DE (EACH ORPECTIVE ACTION SHOULD DE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)           Continued From page 3         V 112         V 112         V         V           Continued From page 3         V 112         V         V         V         V           Ibiashility, Bipolar Mood Disorder and Hyperlipidemia.         V         V         V         V         V           -Vad trained on them when she started working over a year ago.         -'The clients know what their goals are to work on."         -'The clients know what their goals are to work on."         -'The clients know what their goals are to work on."         -'The client was the ant plans at all present in the facility.         -'Staff #1 looking through multiple folders looking for client #2/2 treatment plans are all present in the facility.         V 736         -'Ta6           During Interview on 10/21/20 The Licensee stated: 	

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If continuation sheet 4 of 6

Division	of Health Service R	egulation			FURIN	APPROVE
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED C	
		MHL092610	B. WING			26/2020
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	TATE, ZIP CODE		
BRADLE	Y HOME EXTENSION	I-PKEDS HOUSE	NCES DRIVE			
			k, NC 27529	PROVIDER'S PLAN OF	CORRECTION	()(5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETI DATE
V 736	Continued From pa	age 4	V 736			
	Based on observatives was not maintained attractive manner. Observation on 10/ of the facility revea -Drawer in the kitch wall was missing a -Drawer cover was drawer space down cabinet -Several empty box between the stove -All four of the dinin worn with stains, te -Towel rack in the of missing bar that ho -A knob that held th	/5/20 at approximately 9:55am led: nen under the counter by the cover hanging out of the empty in the front of the bottom kes were piled up in the space and the counter ng room chair cushions were ears and hanging string clients' bathroom had a				
	-She worked every approximately 3-4 I -The boxes belong planning to take the	ed to her and she was em home today. /hen the cabinet in the kitchen				
	During interview & approximately 10:5 -Asked about broke her shoulders and -She would get sor	observation on 10/5/20 at 0am, Licensee reported: en kitchen cabinet, shrugged				
ision of He	[This deficiency col ealth Service Regulation	nstitutes a re-cited deficiency				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL092610		(X2) MULTIPLE A BUILDING <sup>.</sup>		(X3) DATE SURVEY COMPLETED C		
		MHL092610	B. WING		10/26/2020	
AME OF F	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, ST	ATE, ZIP CODE		
	Y HOME EXTENSION		ANCES DRIVE			
		GARNE	R, NC 27529			1
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
V 736	Continued From pa	age 5	V 736			
	and must be corre	cted within 30 days.]				
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