STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL097-073	A. BUILDING: _____ B. WING _____	C 01/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AFL - ESPENSHADE	330 DARNELL LANE WILKESBORO, NC 28697

(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 A complaint survey was completed on 1/6/21. The complaint was unsubstantiated (Intake number#NC00171667) A deficiency was cited. The facility is licensed for the following service category: This facility is licensed for the following service category: 10A NCAC 27G .5600F Supervised Alternative Family Living for Adults with Developmental Disabilities.	V 000		
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	DHSR - Mental Health JAN 28 2021 Lic. & Cert. Section	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: _____ TITLE: REGIONAL DIRECTOR (X6) DATE: 1/13/2021

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V 112	Continued From page 1 This Rule is not met as evidenced by: Based on record review and interview, the facility failed to update a treatment plan with a goal and strategies that addressed the presenting problem for 1 of 1 audited former client (FC #3). The findings are: Record review on 12/31/20 for Former Client (FC #3) revealed: -Date of admission: 12/20/19; -Diagnoses: Schizophrenia, Mild Intellectual Developmental Disability, Asperger's, Hard of Hearing, History (Hx) of Dysuria, Hx of Hyperlipidemia, Seizure Disorder, Irritable Bowel Syndrome, Vitamin B12 Deficiency, Diabetes controlled by diet, Sleep Apnea; -Her treatment plan dated 2/1/20 did not include: -a toileting goal; -strategies that addressed her incontinence episodes. Review on 12/31/20 of written monthly Qualified Professional (QP) contact notes for FC #3 revealed: -the QP notes ranged from December 2019 to August 2020; -2/28/20, she was urinating in her clothes and changed her clothes 3-4 times a day; -4/20/20, she was using the bathroom "excessively" and used the bathroom on herself; -statements were included that she had restrictions approved by a client rights (committee) and there were no changes in her treatment plan;	V 112	The QP with Omni Visions Inc in fact did not update the PCP to address the issues of incontinence. When a client has a new behavior or medical issue arise, the QP needs to add a goal to address the issue in the PCP in agreement with the team. Potential changes in goals will be reviewed monthly with the AFL and treatment team to meet in new concerns or to make changes as needed to existing goals. The goals would reflect the anticipated client outcomes, projected date of achievement, strategies, staff responsible, etc. The consumer that was the subject of the POC is no longer in the home, otherwise the goals would be updated immediately and begin reviewing during the next team meeting. DHSR - Mental H… JAN 2 8 20… Lic. & Cert. …	01/12/2021

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V 112	Continued From page 2 -5/2020 to 8/2020, no changes were made in her treatment plan with updated goals and strategies that addressed her presenting problem and restrictions. Review on 1/6/21 of a printed email chain between the facility's client right's committee members and the QP for FC #3 revealed: -the email chained ranged in dates from 2/17/20 to 3/2/20; -the restriction discussed was no fluids after 7 PM with a final decision made by this committee for FC #3 to be limited to water after 7:30 PM and access to a prescribed mouthwash at all times for dry mouth. Interview on 12/31/20 with FC#3 revealed: -she indicated she had a problem with urination; -at her former placement, she was made to wear pull-ups at night when she went to bed; -she did not wear pull-ups now at all. Interview on 12/29/20 with AFL provider#1 revealed: -she acknowledged that she had incontinence issues since her admission; -she placed her incontinence pullups -she started out once every twenty minutes going to the bathroom. Whenever she was outside and involved in activities, FC#3 was not continuously asking to use the bathroom. Interview on 1/6/21 with QP revealed: -her treatment plan should have been updated to include the changes in FC#3's presenting problem; -she failed to make the changes because there was so much going on at the time.	V 112		