5 STREET ADDRE 625 N MEBAN BURLINGTON NCIES DBY FULL DRMATION)			F CORRECTION TION SHOULD BE THE APPROPRIATE	R K 15/2021
STREET ADDRE 625 N MEBAN BURLINGTON NCIES D BY FULL DRMATION) TVEY WAS plaint was	ESS, CITY, STATE, NE STREET N, NC 27217 ID PREFIX TAG V 000	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO	F CORRECTION TION SHOULD BE THE APPROPRIATE	(X5) COMPLET
625 N MEBAN BURLINGTON NCIES D BY FULL DRMATION) Evey was plaint was	NE STREET N, NC 27217 ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO	TION SHOULD BE	COMPLET
BURLINGTON	N, NC 27217	(EACH CORRECTIVE AC CROSS-REFERENCED TO	TION SHOULD BE	COMPLET
NCIES D BY FULL RMATION) TVey was plaint was	ID PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO	TION SHOULD BE	COMPLET
D BY FULL DRMATION)	V 000	(EACH CORRECTIVE AC CROSS-REFERENCED TO	TION SHOULD BE	COMPLET
rvey was plaint was service ervised				
plaint was service ervised	V 112			
in	V 112			
VICE I on the e client or nin 30 days ted to ted to be id a it least or legally t of he client or nt by the id not be				
	on the e client or in 30 days ed to ed to be d a t least or legally t of e client or t by the	on the e client or in 30 days ed to ed to be d a t least or legally c of e client or it by the	on the e client or in 30 days ed to ed to be d a t least or legally t of e client or t by the	on the   e client or   in 30 days   ed to   ed to be d a t least or legally e client or t by the

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		SURVEY PLETED	
			A. BUILDING:		R	
		MHL001-215	B. WING		04/15/2021	
NAME OF PI	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE,	ZIP CODE		
ALAMANO	CE HOMES		EBANE STREET			
			GTON, NC 27217			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC 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 112	Continued From pag	e 1	V 112			
	failed to develop a cu	iew and interview the facility				
	Review on 4/13/21 o -Admission date of 1 -Diagnoses of Bipola Depressive Disorder Dependency, Chroni -Treatment Plan expl	r Disorder Type I, , NOS, Polysubstance c Back Pain and Arthritis.				
	with clients once a m -She was responsible treatment plans.	d: ntract QP and would meet oonth. e for completing client's eatment plans were current				
	This deficiency const and must be correcte	titutes a re-cited deficiency ed within 30 days.				
V 113	27G .0206 Client Re	cords	V 113			
	(a) A client record sh individual admitted to contain, but need no	6 CLIENT RECORDS all be maintained for each o the facility, which shall t be limited to: ace sheet which includes:				

STATEMEN	of Health Service Regu T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
		MHL001-215	B. WING		R 04/15/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
	CE HOMES		EBANE STREET			
		BURLIN	GTON, NC 27217			
(X4) ID PREFIX TAG	(EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIES     ID     PROVIDER'S PLAN (       (EACH DEFICIENCY MUST BE PRECEDED BY FULL     PREFIX     (EACH CORRECTIVE A       REGULATORY OR LSC IDENTIFYING INFORMATION)     TAG     CROSS-REFERENCED TO				(X5) COMPLET DATE
V 113	Continued From page 2		V 113			
	diagnosis coded acco (3) documentation of assessment; (4) treatment/habilitat (5) emergency inform shall include the nam number of the person sudden illness or acc and telephone number physician; (6) a signed statemen responsible person g emergency care from (7) documentation of (8) documentation of (9) if applicable: (A) documentation of diagnosis according t of Diseases (ICD-9-C (B) medication orders (C) orders and copies (D) documentation of administration errors (b) Each facility shall relative to AIDS or rel only in accordance w	ber; marital status; mental illness, lities or substance abuse ording to DSM IV; the screening and tion or service plan; nation for each client which e, address and telephone n to be contacted in case of ident and the name, address er of the client's preferred nt from the client or legally ranting permission to seek a hospital or physician; services provided; progress toward outcomes; physical disorders to International Classification cM); s; s of lab tests; and				

AME OF PRC			A. BUILDING:				
	MHL001					R	
	OF PROVIDER OR SUPPLIER STREET		B. WING		04/15/2021		
	OVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE			
	EHOMES		EBANE STREET				
(X4) ID			GTON, NC 27217				
PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETI DATE	
V 113 (	Continued From page 3		V 113				
E f f	facility failed to ensur	as evidenced by: ews and interview, the e records were completed d clients (#2). The findings					
- - - - - - - -	-No Admission date. -Diagnoses Schizoaff Type, Seizure Disord Mental Status and Hy -No face sheet and g available.	uardian information essment was available. /ailable. iilable.					
- - - - - - - - - - - - - - - - - - -	-Client #2 received se support team. -The community supp client #2's record abo -Reported the informa record. -Confirmed giving the client #2's original rec -Confirmed he did no -Confirmed he would support team to fax re surveyor.	ation was in client #2's e community support team cord.					
V 118	27G .0209 (C) Medic	ation Requirements	V 118				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			SURVEY PLETED	
		MHL001-215	B. WING		04	R 04/15/2021	
AME OF PF	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	, ZIP CODE			
		625 N M	EBANE STREET				
LAMANC	E HOMES	BURLIN	GTON, NC 27217				
(X4) ID PREFIX TAG	(EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIES         ID         PROVIDER'S PLAN CONTRIBUTION           (EACH DEFICIENCY MUST BE PRECEDED BY FULL         PREFIX         (EACH CORRECTIVE AND CORRECTIVE AN		TION SHOULD BE THE APPROPRIATE	(X5) COMPLE <sup>-</sup> DATE		
V 118	Continued From page 4		V 118				
	only be administered order of a person aut drugs. (2) Medications shall clients only when aut client's physician. (3) Medications, inclu administered only by unlicensed persons to pharmacist or other le privileged to prepare (4) A Medication Adm all drugs administered current. Medications recorded immediately MAR is to include the (A) client's name; (B) name, strength, a (C) instructions for ac (D) date and time the (E) name or initials of drug. (5) Client requests fo checks shall be recor file followed up by ap with a physician.	istration: n-prescription drugs shall to a client on the written horized by law to prescribe be self-administered by horized in writing by the ading injections, shall be licensed persons, or by rained by a registered nurse, egally qualified person and and administer medications. hinistration Record (MAR) of d to each client must be kept administered shall be y after administration. The e following: and quantity of the drug; drug is administering the r medication changes or rded and kept with the MAR pointment or consultation					
	This Rule is not met	as evidenced by:					
	Based on record revi	ew and interview					
	medications shall be	administered only by					

AND PLAN (	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CON A. BUILDING:			E SURVEY PLETED
			A. BOILDING.		—   R	
		MHL001-215	B. WING		04/15/2021	
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE, Z	IP CODE		
ALAMANO	E HOMES		EBANE STREET GTON, NC 27217			
(X4) ID PREFIX TAG	(EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIESIDPROVIDER'S PLAN OF(EACH DEFICIENCY MUST BE PRECEDED BY FULLPREFIX(EACH CORRECTIVE ACTREGULATORY OR LSC IDENTIFYING INFORMATION)TAGCROSS-REFERENCED TO TODEFICIENCEDEFICIENCEDEFICIENCE		ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE	
V 118	Continued From page	e 5	V 118			
	licensed persons, or trained by a registered legally qualified personant administer media three audited staff (S #9). The findings are Review on 4/15/21 of revealed: - No hired date. - Job title: Paraproprise one day off; 8a.m 8 - There was no evide administration training Review on 4/15/21 of revealed: - Hired date: 2012; - Job title: Paraproprise one day off; 8a.m 8 - There was no evide administration training Review on 4/15/21 of revealed: - Hired date: 2012; - Job title: Paraproprise one day off; 8a.m 8 - There was no evide administration training Review on 4/15/21 of revealed: - Hired date: 5/8/19 - Job title: Paraproprise one day off; 8a.m 8 - There was no evide administration training During interview on 4/15/21 of revealed: - There was no evide administration training During interview on 4/15/21 of revealed: - There was no evide administration training During interview on 4/15/21 of revealed: - There was no evide administration training During interview on 4/15/21 of revealed: - There was no evide administration training During interview on 4/15/21 of revealed: - There was no evide administration training During interview on 4/15/21 of revealed: - Staff completed all training - Confirmed a record of their personnel file.	by unlicensed persons ad nurse, pharmacist or other on and privileged to prepare cations affecting three or taff #7, Staff #8 and Staff e: f Staff #7's personnel record ofessional - one day on and Ba.m. dence of medication g in the record. f Staff #8's personnel record g no exact date in record. ofessional - one day on and Ba.m. dence of medication g in the record. f Staff #9's personnel record g in the record. f Staff #9's personnel record b. ofessional - one day on and Ba.m. dence of medication g in the record. f Staff #9's personnel record b. ofessional - one day on and Ba.m. dence of medication g in the record.				

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED	
			A. BUILDING:			R	
		MHL001-215	B. WING		04	/15/2021	
NAME OF PI	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE,	, ZIP CODE			
ALAMANO	CE HOMES		IEBANE STREET IGTON, NC 27217				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE A CROSS-REFERENCED TC DEFICIEI	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLETE DATE	
V 131	Continued From page	e 6	V 131				
V 131	G.S. 131E-256 (D2) Verification	HCPR - Prior Employment	V 131				
	REGISTRY (d2) Before hiring hea health care facility or health care facility sh Personnel Registry a	ALTH CARE PERSONNEL alth care personnel into a service, every employer at a iall access the Health Care nd shall note each incident opriate business files.					
	failed to access the H	ew and interview the facility lealth Care Personnel or to employment for one of					
	revealed: - No hired date. - Job title: Parapro	f Staff #7's personnel record ofessional dence HCP was assessed					
	-He would provide sta surveyor's request. -Confirmed he had al personnel file per sur	I the information for the					
	This deficiency const and must be correcte	itutes a re-cited deficiency ed within 30 days.					

		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C		(X3) DATE SURVEY COMPLETED	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMI	PLETED
		MHL001-215	B. WING	04	R 04/15/2021	
NAME OF PF	ROVIDER OR SUPPLIER	STREETA	ADDRESS, CITY, STATE	, ZIP CODE		
		625 N M	EBANE STREET			
ALAMANC	E HOMES	BURLIN	GTON, NC 27217			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG	``	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	THE APPROPRIATE	COMPLET DATE
V 133	Continued From page	e 7	V 133			
V 133	G.S. 122C-80 Criminal History Record Check		V 133			
	G.S. §122C-80 CRIM	IINAL HISTORY RECORD				
	CHECK REQUIRED	FOR CERTAIN				
	APPLICANTS FOR EMPLOYMENT.					
	(a) Definition As used in this section, the term					
	"provider" applies to an area authority/county program and any provider of mental health,					
		ility, and substance abuse				
		sable under Article 2 of this				
	Chapter.	n offer of employment by a				
	provider licensed under this Chapter to an applicant to fill a position that does not require the					
	applicant to have an occupational license is					
		ent to a State and national				
	criminal history recor	d check of the applicant. If				
	the applicant has bee	en a resident of this State for				
	less than five years,	then the offer of employment				
		sent to a State and national				
	-	d check of the applicant. The				
		ory record check shall				
		e applicant's fingerprints. If				
		en a resident of this State for				
	-	nen the offer is conditioned				
		e criminal history record it. A provider shall not				
		who refuses to consent to a				
		d check required by this				
		herwise provided in this				
		e business days of making				
		of employment, a provider				
		t to the Department of				
		14-19.10 to conduct a				
	criminal history recor	d check required by this				
		it a request to a private				
	-	ate criminal history record				
		s section. Notwithstanding				
	G.S. 114-19.10. the E	Department of Justice shall				1

		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C		(X3) DATE SURVEY COMPLETED		
	OF CORRECTION	IDENTIFICATION NOWBER.	A. BUILDING:		COM		
		MHL001-215	B. WING		04	R 04/15/2021	
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	, ZIP CODE			
		625 N M	EBANE STREET				
ALAMAN	E HOMES	BURLIN	GTON, NC 27217				
AND PLAN OF CORRECTION       IDENTIFICATION NUMBER:       A. BUILD         MHL001-215       B. WING         NAME OF PROVIDER OR SUPPLIER       STREET ADDRESS, CITY         ALAMANCE HOMES       625 N MEBANE STR         BURLINGTON, NC 2       625 N MEBANE STR         (X4) ID       SUMMARY STATEMENT OF DEFICIENCIES       ID         PREFIX       (EACH DEFICIENCY MUST BE PRECEDED BY FULL       PREFI         TAG       REGULATORY OR LSC IDENTIFYING INFORMATION)       TAG         V 133       Continued From page 8       V 133         return the results of national criminal history       record checks for employment positions not       V 133			PROVIDER'S PLAN OF		(X5)		
			PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO		COMPLET DATE	
				DEFICIEN	CY)		
V 133	Continued From page 8		V 133				
	return the results of r	national criminal history					
	•						
	covered by Public La						
	2	and Human Services,					
	Criminal Records Ch	-					
		eipt of the national criminal					
	history of the person, the Department of Health						
		, Criminal Records Check					
	Unit, shall notify the p	provider as to whether the					
	information received	may affect the employability					
	of the applicant. In no	o case shall the results of the					
		ory record check be shared					
	with the provider. Providers shall make available						
	upon request verification that a criminal history						
	check has been completed on any staff covered						
	-	inty that has adopted an					
		nance and has access to					
	-	al Information data bank					
	•	alf of a provider a State					
	-	d check required by this					
		rovider having to submit a					
		tment of Justice. In such a					
	-	Il commence with the State					
	section within five bu	d check required by this					
		nployment by the provider.					
		formation received by the					
		al and may not be disclosed,					
		nt as provided in subsection					
	(c) of this section. Fo						
		"private entity" means a					
	business regularly er	-					
		d checks utilizing public					
	records obtained from	•					
		licant's criminal history					
	record check reveals	one or more convictions of					
	a relevant offense, th	e provider shall consider all					
	-	rs in determining whether to					
	hire the applicant:					1	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED	
		MHL001-215	B. WING		04	R 04/15/2021	
NAME OF PR	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE			
LAMANC	E HOMES		EBANE STREET GTON, NC 27217				
(X4) ID		ATEMENT OF DEFICIENCIES	10			(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	THE APPROPRIATE	COMPLETE DATE	
V 133	Continued From page	9	V 133				
	(1) The level and seri	ousness of the crime.					
	(2) The date of the cri						
	(3) The age of the per	rson at the time of the					
	conviction.						
	(4) The circumstance	-					
	commission of the cri						
	· · /	(5) The nexus between the criminal conduct of the person and the job duties of the position to be					
	filled.	b duties of the position to be					
	(6) The prison, jail, pr	obation parole					
		ployment records of the					
		person since the date the crime was committed.					
	•	(7) The subsequent commission by the person of					
	a relevant offense.						
	The fact of conviction of a relevant offense alone						
		employment; however, the					
		considered by the provider.					
		lifies an applicant after					
		elevant factors, then the information contained in					
		cord check that is relevant					
		, but may not provide a copy					
	of the criminal history						
	applicant.						
	(d) Limited Immunity.	- A provider and an officer					
		vider that, in good faith,					
	-	ction shall be immune from					
	civil liability for:						
	(1) The failure of the lindividual on the basis						
		s of information provided in cord check of the individual.					
	-	n employee's history of					
		e employee's criminal					
		s requested and received in					
	compliance with this	•					
	-	- As used in this section,					
	"relevant offense" me	ans a county, state, or					
		y of conviction or pending					
	indictment of a crime.	whether a misdemeanor or					

	F OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
			A. BUILDING:			
		MHL001-215	B. WING	04	R 04/15/2021	
IAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
	CE HOMES	625 N M	EBANE STREET			
		BURLIN	GTON, NC 27217			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T	ION SHOULD BE	(X5) COMPLETE DATE
				DEFICIENC	Y)	_
V 133	Continued From page 10		V 133			
	felonv. that bears up	on an individual's fitness to				
	have responsibility for the safety and well-being of					
		ntal health, developmental				
		ince abuse services. These				
	,	iminal offenses set forth in				
	any of the following A	Articles of Chapter 14 of the				
	General Statutes: Article 5, Counterfeiting and					
	Issuing Monetary Su	bstitutes; Article 5A,				
	Endangering Executi	ve and Legislative Officers;				
	Article 6, Homicide;	Article 7A, Rape and Other				
	Sex Offenses; Article	e 8, Assaults; Article 10,				
	Kidnapping and Abdu	uction; Article 13, Malicious				
	Injury or Damage by	Injury or Damage by Use of Explosive or				
	Incendiary Device or Material; Article 14, Burglary					
	and Other Housebreakings; Article 15, Arson and					
	Other Burnings; Artic	Other Burnings; Article 16, Larceny; Article 17,				
	Robbery; Article 18,	Embezzlement; Article 19,				
	False Pretenses and	Cheats; Article 19A,				
		r Services by False or				
		edit Device or Other Means;				
	-	I Transaction Card Crime				
		ls; Article 21, Forgery; Article				
	26, Offenses Against					
	-	, Adult Establishments;				
		n; Article 28, Perjury; Article				
		1, Misconduct in Public				
		enses Against the Public				
		Riots and Civil Disorders;				
		of Minors; Article 40,				
		nily; Article 59, Public				
		cle 60, Computer-Related				
		also include possession or tion of the North Carolina				
	•	es Act, Article 5 of Chapter				
		atutes, and alcohol-related				
		e to underage persons in				
	violation of G.S. 18B					
		of G.S. 20-138.1 through				
	G.S. 20-138.5.	01 0.0. 20-100.1 tillough				
	0.0.20-100.0.		1			1

## PRINTED: 04/19/2021 FORM APPROVED

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		E SURVEY PLETED	
		DENTRICATION NOMBER.	A. BUILDING:				
		MHL001-215	B. WING		04	R 1/15/2021	
IAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE			
	E HOMES		EBANE STREET GTON, NC 27217				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED T( DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE	
V 133	Continued From page 11		V 133				
	applicant for employin supplies, or otherwise an employment applie criminal history record shall be guilty of a Cla (g) Conditional Employ employ an applicant of obtaining the results check regarding the a following requirement (1) The provider shall prior to obtaining the criminal history record subsection (b) of this fingerprint cards as re (2) The provider shall criminal history record business days after th conditional employme 2001-155, s. 1; 2004-	of a criminal history record applicant if both of the ts are met: I not employ an applicant applicant's consent for d check as required in section or the completed equired in G.S. 114-19.10. I submit the request for a d check not later than five he individual begins					
1 1 1 1	failed to ensure the si was ordered within fiv the conditional offer of	as evidenced by: ew and interview, the facility tate criminal record check ve business days of making of employment for two of taff #7 and staff #9). The					
	Review on 4/15/21 of revealed: - No hired date. - Job title: Parapro	f Staff #7's personnel record					

VGL011

If continuation sheet 12 of 19

STATEMENT OF DEFICIENCIES () AND PLAN OF CORRECTION		( )		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		
		MHL001-215	B. WING		04	R / <b>15/2021</b>
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
ALAMAN	CE HOMES		EBANE STREET GTON, NC 27217			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN O	F CORRECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	THE APPROPRIATE	COMPLET
V 133	Continued From page	e 12	V 133			
	- There was no evic check was ordered.	dence the criminal record				
	Review on 4/15/21 of revealed: - Hire date: 5/8/19	f Staff #9's personnel record				
	- Job title: Parapro					
	-	/13/21 with Staff #7 revealed oth homes for the company.				
	his criminal backgrou	/15/21 with Staff #9 revealed nd check should be in his e reported paying for the check two times.				
	-He would provide sta surveyor's request. -Confirmed he had al personnel file per sur	l the information for the veyor's request. al record check was not in				
	This deficiency const and must be correcte	itutes a re-cited deficiency d within 30 days.				
V 290	27G .5602 Supervise	d Living - Staff	V 290			
	of this Rule shall be of enable staff to respon needs.	above the minimum Paragraphs (b), (c) and (d) determined by the facility to nd to individualized client e staff member shall be				

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If continuation sheet 13 of 19

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ID PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			SURVEY
			A. BUILDING.			R
		MHL001-215	B. WING		04	/15/2021
AME OF PF	ROVIDER OR SUPPLIER	STREET	DDRESS, CITY, STATE	, ZIP CODE		
LAMANC	E HOMES		EBANE STREET GTON, NC 27217			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN C	OF CORRECTION	(X5)
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIEI	D THE APPROPRIATE	COMPLE DATE
V 290	Continued From pag	e 13	V 290			
	premises, except wh	en the client's treatment or				
		uments that the client is				
	capable of remaining	in the home or community				
		The plan shall be reviewed				
		ss than annually to ensure				
		o be capable of remaining in				
	the home or community without supervision for					
	specified periods of time.					
	(c) Staff shall be present in a facility in the					
	following client-staff ratios when more than one child or adolescent client is present:					
	(1) children or adolescents with substance					
	abuse disorders shall be served with a minimum					
	of one staff present for every five or fewer minor					
	clients present. However, only one staff need be					
	present during sleeping hours if specified by the					
		procedures determined by				
	the governing body;	· ·				
		adolescents with				
	developmental disab	ilities shall be served with				
	one staff present for	every one to three clients				
	-	f present for every four or				
		. However, only one staff				
		ing sleeping hours if				
		rgency back-up procedures				
	determined by the go	<b>o</b> ,				
		n serve clients whose primary				
	-	ce abuse dependency: e staff member who is on				
		in alcohol and other drug				
	withdrawal symptom					
		ions to alcohol and other				
	drug addiction; and					
	•	s of a certified substance				
	abuse counselor sha					
	as-needed basis for	each client.				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
			A. BUILDING: B. WING				
		MHL001-215			04	R <b>I/15/2021</b>	
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE,	ZIP CODE			
LAMANC	CE HOMES		EBANE STREET GTON, NC 27217				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
V 290	Continued From page	e 14	V 290				
	This Rule is not met as evidenced by: Based on record review, observation and interview, the facility failed to ensure supervision in the home affecting one of four audited clients (#3). The findings are: Observation on 4/15/21 at 8:20 a.m. revealed: -Staff #8 was at the back door. -Client #3 was walking from up the block crossing the street to the front of the home. -Staff #8 was not visibly supervising client #3 walked down the block.						
	NOS, Moderate Intel	/5/11. ophrenia, Anxiety Disorder, lectual Functioning, Post order and Hyperlipidemia. d 12/14/20.					
	-He was leaving for the staff #9. -He knew client #3 le -He was unaware who	with Staff #8 revealed: he day waiting for his relief ft the home. ere client #3 walked to. vandered and walked the					
	-Worked as a parapro -He reported surveyo him. -Confirm client #3 wa -Client #3 was suppo and back.	with Staff #9 revealed: ofessional. or would exit the survey with uked down the street. used to walk to the corner					

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED
			A. BUILDING:			Р
	MHL001-215		B. WING		04	R I/ <b>15/2021</b>
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	, ZIP CODE		
ALAMANO	CE HOMES		EBANE STREET GTON, NC 27217			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETE DATE
V 290	Continued From page	a 15	V 290			
		nt #3 walk down the street				
V 736	27G .0303(c) Facility	and Grounds Maintenance	V 736			
		EMENTS				
		n, the facility failed to ensure maintained in a safe, clean				
		21 at 10am revealed: door knob on door needs to vas kept in the staff				
	bathroom bathtub Camera hanging or where staff sleep and grooming.	n wall in the office area for I complete personal				
	-Door to client's bath door from being able -Bathroom lighting wa -Bathroom smelled o	as dim.				
	-Toilet tissue holder n -No paper towel or ha to dry hands.	eeded in bathroom. and towel available for clients				
	closed.	der sink did not completely r-right corner unable to				

6899

If continuation sheet 16 of 19

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED	
			A. BUILDING: B. WING		R 04/15/2021	
		MHL001-215				
AME OF PF	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE,	ZIP CODE		
LAMANC	E HOMES		EBANE STREET GTON, NC 27217			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLET DATE
V 736	Continued From page	e 16	V 736			
	the door -Kitchen drawer in rig drawer. -Hallway area closest no lighting. -First bedroom to the urine and large black -First bedroom to the dresser drawer. -First bedroom to the a dresser. -Second bedroom to the replaced in ceiling far -First bedroom to the replaced. -First bedroom to the replaced in ceiling far -Removal of all old sr of all bedrooms and h -All doors and walls v cleaned and painted. Interview on 4/15/21 -Surveyors was allow him. -Confirmed issues in -Reported the Director	right needed doorknob right needed 2 lightbulbs n fixture. noke detectors above door nad exposed wires. vere dirty and need to be with Staff #9 revealed: red to exit the survey with				
	This deficiency const and must be correcte	itutes a re-cited deficiency d within 30 days.				
V 738	27G .0303(d) Pest Co	ontrol	V 738			
	10A NCAC 27G .030 EXTERIOR REQUIR					

VGL011

If continuation sheet 17 of 19

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		E SURVEY PLETED	
			A. BUILDING:			
		MHL001-215	B. WING		04	R / <b>15/2021</b>
NAME OF PI	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE,	, ZIP CODE		
	CE HOMES		EBANE STREET			
	CUMMADY C		GTON, NC 27217	PROVIDER'S PLAN OF		
(X4) ID PREFIX TAG	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 738	Continued From pag	e 17	V 738			
	(d) Buildings shall be rodents.	e kept free from insects and				
	This Rule is not met as evidenced by: Based on observation and interviews the facility failed to maintain an insect free environment. The findings are: Observation on 4/13/21 at 10:35 a.m. revealed: -There was a mouse trap on the floor in the first bedroom on the right of the back door.					
	Client #3, Client #5 a -No one reported see -All denied the home -Client #5 reported th room.	with Clients #1, Client #2, and Client #6 revealed: eing bed bugs in the home. had issues with bed bugs. he mouse trap was in his here was a mouse "running"				
	-Client #6 reported h -Client #5 and client came quarterly.	#2 did not see any rodents. e killed about three mice. #6 reported the exterminator e're near a land and grass.				
	The mice would keep -Client #4 was unava	o coming."				
	-She worked at the h day on and one day -She did not see any -Clients did not repor					
	Interview on 4/13/21 alth Service Regulation	with the Director revealed:				

TATEMEN	of Health Service Regu OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED R 04/15/2021	
		MHL001-215				
AME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	ZIP CODE		
	CE HOMES		EBANE STREET GTON, NC 27217			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENT	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 738	Continued From pag	e 18	V 738			
	to exterminate the fa -Last year a former of outside. -No one at the home bugs. -It was a complaint w him for a short time. -They just took preca -He purchased new r home. -There was no extern	with an exterminator company cility quarterly. dient was bringing stuff from reported or ever seeing bed with people that worked with autions to get treatment. mattresses throughout the minator receipts produced st on before or on exit.				