STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL001-187	A. BUILDING: ______ B. WING ______	R 08/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEESONS OF CHANGE	**1536 MORNINGSIDE DRIVE BURLINGTON, NC 27217**

(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 and follow up survey was completed on August 9, 2021. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600A Supervised Living for Adults with Mental Illness.	V 000		
V 107	27G .0202 (A-E) Personnel Requirements 10A NCAC 27G .0202 PERSONNEL REQUIREMENTS (a) All facilities shall have a written job description for the director and each staff position which: (1) specifies the minimum level of education, competency, work experience and other qualifications for the position; (2) specifies the duties and responsibilities of the position; (3) is signed by the staff member and the supervisor; and (4) is retained in the staff member's file. (b) All facilities shall ensure that the director, each staff member or any other person who provides care or services to clients on behalf of the facility: (1) is at least 18 years of age; (2) is able to read, write, understand and follow directions; (3) meets the minimum level of education, competency, work experience, skills and other qualifications for the position; and (4) has no substantiated findings of abuse or neglect listed on the North Carolina Health Care Personnel Registry. (c) All facilities or services shall require that all applicants for employment disclose any criminal conviction. The impact of this information on a decision regarding employment shall be based	V 107		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL001-187	A. BUILDING: ______ B. WING ______	R 08/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEESONS OF CHANGE	1536 MORNINGSIDE DRIVE BURLINGTON, NC 27217

(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 107	Continued From page 1 upon the offense in relationship to the job for which the applicant is applying. (d) Staff of a facility or a service shall be currently licensed, registered or certified in accordance with applicable state laws for the services provided. (e) A file shall be maintained for each individual employed indicating the training, experience and other qualifications for the position, including verification of licensure, registration or certification. This Rule is not met as evidenced by: Based on records review and interview the facility failed to ensure one of four audited staff (#2) met the minimum level of education requirement and had complete personnel records. The findings are: Review on 8/9/21 of staff #2's personnel record revealed: -Hire date of 7/6/14. -She was hired as a Residential Counselor. -She worked on 3rd shift and alternated on weekends. -There was no evidence of educational credentials. Interview on 8/9/21 with the Director revealed: -After last survey in 2019, staff had brought in their educational credentials to him. -He thought copies of their educational	V 107		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL001-187	A. BUILDING: ______ B. WING ______	R 08/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEESONS OF CHANGE	1536 MORNINGSIDE DRIVE BURLINGTON, NC 27217

(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 107	Continued From page 2 credentials were in their personnel files. -He confirmed staff #2's personnel record did not include educational credentials. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 107		
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		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL001-187	A. BUILDING: ______ B. WING ______	R 08/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEESONS OF CHANGE	**1536 MORNINGSIDE DRIVE BURLINGTON, NC 27217**

(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 112	Continued From page 3 This Rule is not met as evidenced by: Based on record reviews and interview, the facility failed to have a Person Centered Plan with 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 affecting three of three audited clients (#1, #2 and #3). The findings are: Review on 8/9/21 of client #1's record revealed: -Admission date of 5/13/12. -Diagnoses of Depression; Tobacco Use; Dermatitis; Asthma; Psoriasis; Allergic Rhinitis; Mixed Hyperlipidemia. -Signature page of the Person Centered Plan was not signed by the client or responsible party. Review on 8/9/21 of client #2's record revealed: -Admission date of 10/16/18. -Diagnoses of Schizophrenia; Dysphoric -Signature page of the Person Centered Plan was not signed by the client or responsible party. Review on 8/9/21 of client #3's record revealed: -Admission date of 11/3/20. -Diagnoses of Schizophrenia; Moderate Intellectual Disability; Vitamin D Deficiency. -Signature page of the Person Centered Plan was not signed by the client or responsible party. Interview on 8/9/21 with the Director revealed: -The Qualified Professional was responsible for completing the Person Center Plans. -The Qualified Professional had updated the Person Centered Plans for all clients reviewed, but had not been able to get their legal guardian's signatures.	V 112		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL001-187	A. BUILDING: ______ B. WING ______	R 08/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEESONS OF CHANGE	**1536 MORNINGSIDE DRIVE BURLINGTON, NC 27217**

(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 112	Continued From page 4 -Some things had not been getting done due to current COVID situation. -He confirmed that clients #1, #2 and #3 had no updated signed Person Centered Plans in their charts. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 112		
V 113	27G .0206 Client Records 10A NCAC 27G .0206 CLIENT RECORDS (a) A client record shall be maintained for each individual admitted to the facility, which shall contain, but need not be limited to: (1) an identification face sheet which includes: (A) name (last, first, middle, maiden); (B) client record number; (C) date of birth; (D) race, gender and marital status; (E) admission date; (F) discharge date; (2) documentation of mental illness, developmental disabilities or substance abuse diagnosis coded according to DSM IV; (3) documentation of the screening and assessment; (4) treatment/habilitation or service plan; (5) emergency information for each client which shall include the name, address and telephone number of the person to be contacted in case of sudden illness or accident and the name, address and telephone number of the client's preferred physician; (6) a signed statement from the client or legally responsible person granting permission to seek emergency care from a hospital or physician; (7) documentation of services provided; (8) documentation of progress toward outcomes;	V 113		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL001-187	A. BUILDING: ______ B. WING ______	R 08/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEESONS OF CHANGE	**1536 MORNINGSIDE DRIVE BURLINGTON, NC 27217**

(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 113	Continued From page 5 (9) if applicable: (A) documentation of physical disorders diagnosis according to International Classification of Diseases (ICD-9-CM); (B) medication orders; (C) orders and copies of lab tests; and (D) documentation of medication and administration errors and adverse drug reactions. (b) Each facility shall ensure that information relative to AIDS or related conditions is disclosed only in accordance with the communicable disease laws as specified in G.S. 130A-143. This Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure three of three client's (#1, #2 and #3) records contained the required information. The findings are: Review on 8/9/21 of client #1's record revealed: -Admission date of 5/13/12. -Diagnoses of Depression; Tobacco Use; Dermatitis; Asthma; Psoriasis; Allergic Rhinitis; Mixed Hyperlipidemia. -There were no signed consent forms for services. -There was no signed consent for granting permission to seek emergency care from a hospital or physician. Review on 8/9/21 of client #2's record revealed: -Admission date of 10/16/18. -Diagnoses of Schizophrenia; Dysphoric -There were no signed consent forms for	V 113		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL001-187	A. BUILDING: ______ B. WING ______	R 08/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEESONS OF CHANGE	**1536 MORNINGSIDE DRIVE BURLINGTON, NC 27217**

(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 113	Continued From page 6	V 113		

services.
-There was no signed consent for granting permission to seek emergency care from a hospital or physician.

Review on 8/9/21 of client #3's record revealed:
-Admission date of 11/3/20.
-Diagnoses of Schizophrenia; Moderate Intellectual Disability; Vitamin D Deficiency.
-There were no signed consent forms for services.
-There was no signed consent for granting permission to seek emergency care from a hospital or physician.

Interview on 8/9/21 with the Director revealed:
-He was responsible for gathering admissions package which included required consents for services
-Some things had not been getting done due to current COVID situation.
-He confirmed that facility failed to ensure clients records contained the required information.

V 118 | 27G .0209 (C) Medication Requirements | V 118

10A NCAC 27G .0209 MEDICATION REQUIREMENTS
(c) Medication administration:
(1) Prescription or non-prescription drugs shall only be administered to a client on the written order of a person authorized by law to prescribe drugs.
(2) Medications shall be self-administered by clients only when authorized in writing by the client's physician.
(3) Medications, including injections, shall be administered only by licensed persons, or by unlicensed persons trained by a registered nurse,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL001-187	A. BUILDING: ______ B. WING ______	R 08/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEESONS OF CHANGE	**1536 MORNINGSIDE DRIVE BURLINGTON, NC 27217**

(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 118	Continued From page 7 pharmacist or other legally qualified person and privileged to prepare and administer medications. (4) A Medication Administration Record (MAR) of all drugs administered to each client must be kept current. Medications administered shall be recorded immediately after administration. The MAR is to include the following: (A) client's name; (B) name, strength, and quantity of the drug; (C) instructions for administering the drug; (D) date and time the drug is administered; and (E) name or initials of person administering the drug. (5) Client requests for medication changes or checks shall be recorded and kept with the MAR file followed up by appointment or consultation with a physician. This Rule is not met as evidenced by: Based on observation, record reviews and interview, the facility failed to have physician orders for administered medications affecting one of three audited clients (client #3). Review on 8/9/21 of client #3's record revealed: -Admission date of 11/3/20. -Diagnoses of Schizophrenia; Moderate Intellectual Disability; Vitamin D Deficiency. Review on 8/9/21 of Client #3's physician's orders revealed: -There was no written order for Atorvastatin 20 milligram (mg), one tablet at bedtime. -There was no written order for Vascepa 1 gram,	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL001-187	A. BUILDING: ______ B. WING ______	R 08/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEESONS OF CHANGE	**1536 MORNINGSIDE DRIVE BURLINGTON, NC 27217**

(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 118	Continued From page 8 2 capsules twice a day. Observation on 8/9/21 of Client #3's medications revealed: -Atorvastatin 20 mg was available. -Vascepa 1 gram was available. Review on 8/9/21 of Client #3's Medication Administration Record for June 2021 through August 2021 revealed: -Medication had been marked as given daily. Interviews on 8/9/21 with the Director revealed: -He thought all of the client's physician's orders were in their file. -He acknowledged that some things had been forgotten to do due to COVID situation. -He confirmed that there were no written physician's order for client #3's Atorvastatin and Vascepa on file.	V 118		
V 121	27G .0209 (F) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (f) Medication review: (1) If the client receives psychotropic drugs, the governing body or operator shall be responsible for obtaining a review of each client's drug regimen at least every six months. The review shall be to be performed by a pharmacist or physician. The on-site manager shall assure that the client's physician is informed of the results of the review when medical intervention is indicated. (2) The findings of the drug regimen review shall be recorded in the client record along with corrective action, if applicable.	V 121		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL001-187	A. BUILDING: ______ B. WING ______	R 08/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEESONS OF CHANGE	**1536 MORNINGSIDE DRIVE BURLINGTON, NC 27217**

(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 121	Continued From page 9	V 121		

This Rule is not met as evidenced by:
Based on record reviews and interview the facility failed to obtain drug reviews every six months for two of three clients (#2 and #3) who received psychotropic drugs. The findings are:

Review on 8/9/21 of client #2's record revealed:
-Admission date of 10/16/18.
-Diagnoses of Schizophrenia; Dysphoric
-Physician's order dated 1/21/21 for Trazodone 100 milligram (mg), one tablet at bedtime.
-Physician's order dated 6/4/21:
 -Fanapt 6 mg, one tablet twice a day.
 -Sertraline 100 mg, one tablet a day.
 -Levetiracetam 750 mg, one tablet twice a day.
 -Tegretol 200 mg, four tablets twice a day.
-The June, July and August 2021 Medication Administration Record (MAR) revealed client #2 was administered the above medications daily.
-There was no evidence of a six month psychotropic drug review for client #2.

Review on 8/9/21 of client #3's record revealed:
-Admission date of 11/3/20.
-Diagnoses of Schizophrenia; Moderate Intellectual Disability; Vitamin D Deficiency.
-Physician's order dated 11/4/20 for Olanzapine 20 mg, one tablet at night.
-The June, July and August 2021 Medication Administration Record (MAR) revealed client #3 was administered the above medications daily.
-There was no evidence of a six month psychotropic drug review for client #3.

Interview on 1/14/20 with the Director revealed:
-He was not aware that a psychotropic drug

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL001-187	A. BUILDING: ______ B. WING ______	R 08/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEESONS OF CHANGE	**1536 MORNINGSIDE DRIVE BURLINGTON, NC 27217**

(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 121	Continued From page 10 review for clients #2 and #3 had not been completed. -He received information from pharmacist that due to COVID situation, she had not been able to attend group home to complete the 6 months drug reviews. -He confirmed the six months psychotropic drug review for clients #2 and #3 were not completed.	V 121		
V 736	27G .0303(c) Facility and Grounds Maintenance 10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS (c) Each facility and its grounds shall be maintained in a safe, clean, attractive and orderly manner and shall be kept free from offensive odor. This Rule is not met as evidenced by: Based on observation and interview, the facility failed to ensure facility grounds were maintained in a clean, attractive and orderly manner and kept free from offensive odor. The findings are: Observation on 8/9/21 at about 12:20 pm of the Kitchen area revealed: -There was mold/mildew on the back side of the sink next to the wall. Observation on 8/9/21 at about 12:25 pm of the bedroom next to the dining area revealed: -Walls were dirty/stained/scratched. -Light on the ceiling fan was non functional. Observation on 8/9/21 at about 12:28 pm of the	V 736		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL001-187	A. BUILDING: ______ B. WING ______	R 08/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEESONS OF CHANGE	**1536 MORNINGSIDE DRIVE BURLINGTON, NC 27217**

(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 736	Continued From page 11 Hallway leading to the client's bedrooms revealed: -Fire extinguisher expired on June 2021. -Walls were dirty/stained/scratched. Observation on 8/9/21 at about 12:30 pm of the bedroom left to the bathroom revealed: -There was a strong smell of body odor. -Baseboard around the room was dirty with heavy lint. Observation on 8/9/21 at about 12:33 pm of the bathroom revealed: -There was a strong smell of urine. -Toilet bowl was dirty/stained. -There was mold/mildew around the wall inside the shower. -There was mold/mildew around the tub. -Walls were dirty/stained. Observation on 8/9/21 at about 12:38 pm of the bedroom on the right to the bathroom revealed: -Walls were dirty/stained. Observation on 8/9/21 at about 12:45 pm of the outside grounds of the facility revealed: -There were two lawnmowers and other yard equipment next to the back wall of the house. -There was trash on the side of the house, next to the garbage bins. -Carport was cluttered with yard equipment and tools around the floor. Observation on 8/9/21 at about 12:48 pm of the side porch revealed: -Side door entrance to the house was dirty and paint was chipping off. -Side door had a broken window. Interview on 8/9/21 with the Director revealed:	V 736		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL001-187	A. BUILDING: ______ B. WING ______	R 08/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEESONS OF CHANGE	**1536 MORNINGSIDE DRIVE BURLINGTON, NC 27217**

(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 736	Continued From page 12 -Agency was responsible for doing maintenance for the home. -One of the residents had a cultural issue of not wearing deodorant. -One of the residents had a yard maintenance business and collected yard equipment. -Client was in process of decluttering the car port. -He was going to pay one of the residents to take care of some of the maintenance issues. -He confirmed the facility failed to ensure facility grounds were maintained in a clean, attractive and orderly manner and kept free from offensive odor. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 736		