STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL025-205	A. BUILDING: _____ B. WING _____	R 12/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDELL'S ONE	3717 TRENT ROAD NEW BERN, NC 28560

(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 December 2, 2021. A deficiency was cited. This facility is licensed for the following service category: 10 A NCAC 27G .5600F, Supervised Living/Alternative Family Living. The survey sample consisted of audits of 3 current clients.	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		

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V 112	Continued From page 1	V 112		

This Rule is not met as evidenced by:
Based on record reviews and interviews the facility failed to review the treatment plan annually in partnership with the client or legally responsible person affecting 1 of 3 clients (#1). The findings are:

Review on 12/1/21 of client #3's record revealed:
- 66 year old male admitted to the facility 5/30/12.
- Diagnoses included Schizophrenia- Residual type, Intellectual Developmental Disability-Moderate, High Cholesterol, High Blood Pressure, Seizure Disorder and Ulcers.
- Legal guardian identified as client #4.
- "Individual Support Plan" implemented 9/1/21 completed and signed by the Local Management Entity Care Coordinator 7/19/21.
- No individual or leally responsible person signature on the "Individual Support Plan."

During interview on 12/1/21 client #3 stated he loved living there, he took his medicine everyday and he liked to go out with his worker.

During interview on 12/1/21 and 12/2/21 the AFL Provider/Licensee stated that client #3's treatment team meeting was held over a virtual platform. She and client #3 were attended the treatment team virtually. She thought that the team had put a statement about the current pandemic on the signature page. The Qualified Professional wrote the treatment plans. She would speak with the Qualified Professional and the Local Management Entity Care Coordinator

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V 112	Continued From page 2 about obtaining client #3's signature on his current treatment plan. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 112		