Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				X3) DATE SURVEY COMPLETED	
ANDILAN	or doring of the state of the s	IDENTIFICATION NOMBER.	A. BUILDING:		J COWII EL	.125	
		MHL049-145	B. WING		11/17	7/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE			
THE GRO	VE		TNUT GROVE				
			LLE, NC 28625				
(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 CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE	
V 000	INITIAL COMMENTS	;	V 000				
	on 11/17/2021. The cunsubstantiated (intal NC183039). Deficien This facility is license category: 10A NCAC	ke #NC182432 &					
V 118	27G .0209 (C) Medica	ation 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, 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						

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			
		MHL049-145	B. WING		11	/17/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STAT	E, ZIP CODE	-	
THE ODO		247 CHE	STNUT GROVE R	OAD		
THE GRO	VE	STATESV	ILLE, NC 28625			
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
V 118	Continued From page	. 1	V 118			
<b>V</b> 1.10		pointment or consultation	VIII			
	facility failed to ensure medications was docu	ews and interviews, the eadministration of umented immediately on affecting 3 of 3 clients				
	#1's record revealed: - Admission date: 8/13 - Diagnoses: Moderat Autism Spectrum Disc Type I (condition that the brain, nerves and (eating non-food items Insomnia - Age: 18 years, 4 mo - Physician's orders for - Clonidine 0.1 mg (revery morning), date - Clonidine 0.1 mg, 2 bedtime), dated 6/4/2 - Melatonin 3mg, 1 to dated 6/4/2021; - PEG powder (polye grams in 8 oz. (ounce day), dated 6/4/2021; - Risperidone 1mg, 2 (twice daily), dated 6/4	e Intellectual Disabilities; order; Neurofibromatosis, causes tumors to form on spinal column); PICA s); Constipation; and on the following medications: milligrams), 1 tablet QAM d 6/4/2021; 2 tablets QHS (every night at 1021 ablet QPM (every evening), ethylene glycol), dissolve 17 s) liquid and give QD (every 1-1/2 tablets (=1.5mg) BID				

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STATE FORM 6899 0LXQ11 If continuation sheet 2 of 9

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COMPLETED		
		MHL049-145	B. WING		11/17/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
		247 CHE	STNUT GROVE	ROAD		
THE GRO	VE	STATES	/ILLE, NC 2862	5		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE	
V 118	Continued From page	2	V 118			
	#1's MARs for Septer November of 2021 re - Each medication had blank on the space us document medication - There were a total of September MAR.  - There were a total of MAR.  - There were a total of MAR.  Reviews on 11/12/202 #2's record revealed:  - Admission date: 3/12 - Diagnoses: Autistic Explosive Disorder; M Spastic diplegic cerebic disorder of speech and allergy to other foods:  - Age: 12 years, 9 mo - Physician's orders for - Aripiprazole 5mg, 68/24/2021;  - Citalopram 10mg, dose to equal 30mg, 60 - Citalopram 20mg, 60 - Citalopram 20 - Citalopram 20mg, 60 - Citalopram 20 - Citalopram 20 - Citalopra	vealed: d at least one date with a sed for facility staff to administration. f 30 blanks on the f 32 blanks on the October  21 and 11/15/2021 of Client  8/2021 Disorder; Intermittent filld Intellectual Disabilities; oral palsy; Developmental ad language, Dermatitis; and onths. or the following medications: 1 tablet BID, dated  1 tablet QHS with 20mg dated 7/13/2021; 1 tablet QHS with 10mg dated 7/13/2021; 1 tablet TID (three times 1; 1 tablet QAM, dated  7mg, 1 tablet after				
	#2's MARs for Septer November of 2021 re					

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blank on the space used for facility staff to

STATE FORM 6899 0LXQ11 If continuation sheet 3 of 9

<u>of Health Service Regu</u>	iation					
OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 1		(X3) DATE SURVEY COMPLETED		
	MHL049-145	B. WING		11/17/2021		
ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE			
	247 CHE	STNUT GROVE	ROAD			
THE GROVE STATESVILLE, NC 28625						
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD	D BE COMPLETE		
document medication	administration.	V 118				
September MAR.						
Reviews on 11/12/202 #3's record revealed:	21 and 11/15/2021 of Client					
- Diagnoses: Autism S	Spectrum Disorder; Mild					
with right estopia (straboth eyes turn inward	abismus in which one or ); Severe Cerebellar					
Extreme immaturity.	•					
<ul> <li>- Age: 18 years, 10 months.</li> <li>- Physician's orders for the following medications:</li> <li> Baclofen 20mg, 1 tablet TID, dated 6/4/2021;</li> <li> Cetirizine 10mg, 1 tablet OD dated 6/4/2021;</li> </ul>						
each nostril prior to a						
Divalproex 125mg, dated 6/4/2021;						
dated 6/4/2021;						
6/4/2021; Fluticasone 50mcg	(micrograms), 1 spray in					
Fluvoxamine 100m	ng, 1 tablet BID with 50mg to					
Fluvoxamine 50mg	, 1 tablet BID with 100mg to					
6/4/2021;						
	SUMMARY STI (EACH DEFICIENCY  Continued From page document medication - There were a total or September MAR.  There were a total or MAR.  Reviews on 11/12/202 #3's record revealed: - Admission date: 4/12 - Diagnoses: Autism sintellectual disability; with right estopia (strate) both eyes turn inward Atrophy; Gastrostomy Extreme immaturity Age: 18 years, 10 m - Physician's orders for - Baclofen 20mg, 11 - Cetirizine 10mg, 11 - Deep Sea nasal speach nostril prior to addated 6/4/2021; - Divalproex 125mg, dated 6/4/2021; - Fish oil softgel 500 6/4/2021; - Flutosamine 50mcg each nostril QD, dated 6/4/2021; - Flutosamine 50mcg equal 150mg, dated 6/4/2021; - Fluvoxamine 50mcg equal 150mg, dated 6/6/4/2021; - Fluvoxamine 50mcg equal 150mg, dated 6/6/2021; - Floyoxamine 50mcg equal 150mg, dated 6/6/2021;	MHL049-145  ROVIDER OR SUPPLIER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 3  document medication administration.  - There were a total of 30 blanks on the September MAR.  - There were a total of 51 blanks on the October MAR.  Reviews on 11/12/2021 and 11/15/2021 of Client #3's record revealed:  - Admission date: 4/1/2020.  - Diagnoses: Autism Spectrum Disorder; Mild intellectual disability; Cerebral Palsy; Strabismus with right estopia (strabismus in which one or both eyes turn inward); Severe Cerebellar Atrophy; Gastrostomy tube; History of stroke; and Extreme immaturity.  - Age: 18 years, 10 months.  - Physician's orders for the following medications:  - Baclofen 20mg, 1 tablet TID, dated 6/4/2021;  - Cetirizine 10mg, 1 tablet QD, dated 6/4/2021;  - Deep Sea nasal spray 0.65%, use 5 sprays in each nostril prior to administration of fluticasone, dated 6/4/2021;  - Divalproex 125mg, 3 capsules (=375mg) QAM, dated 6/4/2021;  - Divalproex 125mg, 4 capsules (=500mg) QHS, dated 6/4/2021;  - Fish oil softgel 500mg, 1 tablet QD, dated 6/4/2021;  - Fish oil softgel 500mg, 1 tablet BID with 50mg to equal 150mg, dated 6/4/2021;  - Fluvoxamine 50mg, 1 tablet BID with 50mg to equal 150mg, dated 6/4/2021;  - Fluvoxamine 50mg, 1 tablet BID with 100mg to equal 150mg, dated 6/4/2021;  - Propranolol 20mg, 1 tablet TID, dated	TOF DEFICIENCIES OF CORRECTION  (X1) PROVIDER SUPPLIER CORRECTION  MHL049-145  STREET ADDRESS, CITY, STA 247 CHESTNUT GROVE IS TATESVILLE, NC 28628  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 3  document medication administration There were a total of 30 blanks on the September MAR There were a total of 51 blanks on the October MAR.  Reviews on 11/12/2021 and 11/15/2021 of Client #3's record revealed: - Admission date: 4/1/2020 Diagnoses: Autism Spectrum Disorder; Mild intellectual disability; Cerebral Palsy; Strabismus with right estopia (strabismus in which one or both eyes turn inward); Severe Cerebellar Atrophy; Gastrostomy tube; History of stroke; and Extreme immaturity Age: 18 years, 10 months Physician's orders for the following medications: - Baclofen 20mg, 1 tablet TID, dated 6/4/2021; - Cetirizine 10mg, 1 tablet QD, dated 6/4/2021; - Divalproex 125mg, 3 capsules (=375mg) QAM, dated 6/4/2021; - Divalproex 125mg, 4 capsules (=500mg) QHS, dated 6/4/2021; - Fish oil softgel 500mg, 1 tablet QD, dated 6/4/2021; - Fish oil softgel 500mg, 1 tablet BID with 50mg to equal 150mg, dated 6/4/2021; - Fluvoxamine 50mg, 1 tablet BID with 50mg to equal 150mg, dated 6/4/2021; - Fluvoxamine 50mg, 1 tablet BID with 100mg to equal 150mg, dated 6/4/2021; - Fluvoxamine 50mg, 1 tablet BID with 100mg to equal 150mg, dated 6/4/2021; - Fluvoxamine 50mg, 1 tablet BID with 100mg to equal 150mg, dated 6/4/2021; - Fluvoxamine 50mg, 1 tablet TID, dated 6/4/2021; - Fluvoxamine 50mg, 1 tablet BID with 100mg to equal 150mg, dated 6/4/2021; - Fluvoxamine 50mg, 1 tablet TID, dated 6/4/2021;	CATE   DEFICIENCIES   (X1) PROVIDER/RUPPLIERICLIA   DENTIFICATION NUMBER:   A BUILDING:   B. WING   B. WING   B. WING   B. WING   B. WING   B. WING   STATESVILLE, NC 28625		

Division of Health Service Regulation

6/4/2021.

Reviews on 11/12/2021 ad 11/15/2021 of Client

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		(X3) DATE SURVEY COMPLETED
		A. BUILDING: _			
		MHL049-145	B. WING	<del></del>	11/17/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
THE GROVE			NUT GROVE		
		STATESVIL	LE, NC 28625		
(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 CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
V 118	Continued From page	e 4	V 118		
	blank on the space us document medication - There were a total of September MAR.	vealed: d at least one date with a sed for facility staff to administration.			
	Interview on 11/16/2021 with the Residential Team Leader (RTL) revealed: - Nursing staff reviewed MARs for completeness and accuracy There was a possibility that some of the blanks on the MARs were due to clients being on home visits She believed that Clients' #1, #2 and #3 had been administered all of their medications correctly.				
	Interviews on 11/16/2021 and 11/17/2021 with the Qualified Professional (QP) revealed: - She did not typically oversee MARs the Registered Nurse (RN) showed her the MARs with missing documentation The RN was already addressing the documentation issues with the MARs.				
	- She had reviewed the begun investigating was some of the blanks been on home visits Facility staff had been home visits on the Market She compared the Market sure that the medications were				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _			
		MHL049-145	B. WING		11	/17/2021
NAME OF PE	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	E, ZIP CODE		
THE CROY	.re	247 CHE	STNUT GROVE R	OAD		
THE GRO	VE	STATES	VILLE, NC 28625			
(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 COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
V 118	Continued From page	÷ 5	V 118			
	certification for some	of the facility staff and e-trained in medication provements with				
V 289	27G .5601 Supervise	d Living - Scope	V 289			
	provides residential shome environment where the services is the control of individual shows a development or a substance abuse supervision when in the facility serves eith (1) one or more (2) two or more (2) two or more Minor and adult client same facility. (c) Each supervised licensed to serve a specific designated below:  (1) "A" designated serves adults whose pillness but may also here (2) "B" designated below:  (1) "B" designated below:  (2) "B" designated below:  (3) "C" designated below:  (4) "B" designated below:  (5) "B" designated below:  (6) "B" designated below:  (7) "B" designated below:  (8) "C" designated below:  (9) "B" designated below:  (1) "C" designated below:  (1) "C" designated below:  (3) "C" designated below:  (4) "B" designated below:  (5) "C" designated below:  (6) "B" designated below:  (7) "C" designated below:  (8) "C" designated below:  (9) "B" designated below:  (1) "C" designated below:  (1) "A" designated below:  (2) "B" designated below:  (3) "C" designated below:  (4) "B" designated below:  (5) "B" designated below:  (6) "B" designated below:  (7) "B" designated below:  (8) "B" designated below:  (9) "B" designated below:  (1) "B" designated below:  (2) "B" designated below:  (3) "C" designated below:  (4) "B" designated below:  (5) "B" designated below:  (6) "B" designated below:  (7) "B" designated below:  (8) "B" designated below:  (9) "B" designated below:  (1) "B" designated below:  (1) "B" designated below:  (2) "B" designated below:  (3) "C" designated below:  (4) "B" designated below:  (5) "B" designated below:  (6) "B" designated below:  (7) "B" designated below:  (8) "B" designated below:  (9) "B" designated below:  (1) "B" designated below:  (1) "B" designated below:  (1) "B" designated below:  (2) "B" designated below:  (3) "B" designated below:  (4) "B" designated below:  (5) "B" designated below:  (6) "B" designated below:  (7) "B" designated below:  (8) "B" designated below:  (9) "B" designated below:  (1) "B" designated below:  (1) "B" designated below:  (2) "B	is a 24-hour facility which ervices to individuals in a here the primary purpose of care, habilitation or duals who have a mental stal disability or disabilities, a disorder, and who require the residence. If a facility shall be licensed if the error of a cault clients; or a cault clients. It is shall not reside in the living facility shall be pecific population as to means a facility which primary diagnosis is mental that ave other diagnoses; the means a facility which primary diagnosis is a lity but may also have other tion means a facility which primary diagnosis is a lity but may also have other tion means a facility which primary diagnosis is a lity but may also have other tion means a facility which primary diagnosis is a lity but may also have other tion means a facility which primary diagnosis is a lity but may also have other tion means a facility which				

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STATE FORM 6899 0LXQ11 If continuation sheet 6 of 9

Division of Health Service Regulation

		(X1) PROVIDER/SUPPLIER/CLIA			(X3) DATE SURV	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	ETED
		MHL049-145	B. WING		11/1	7/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STAT	TE, ZIP CODE		
THE CRO	\/E	247 CHES	TNUT GROVE F	ROAD		
THE GRO	VE	STATESVI	LLE, NC 28625	;		
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
V 289	Continued From page	e 6	V 289			
V 289	substance abuse depother diagnoses; (5) "E" designal serves adults whose substance abuse depother diagnoses; or (6) "F" designal private residence, who three adult clients who mental illness but madisabilities, or three actions whose primary developmental disabilities who family provides the seexempt from the follo .0201 (a)(1),(2),(3),(4) (A),(B),(E),(F),(G),(H),(18) and (b); 10A NCAC 27G .0208 (b),(e); 10 non-prescription med (1)(A),(D),(E);(f);(g); a (b)(2),(d)(4). This factories	tion means a facility which primary diagnosis is sendency but may also have tion means a facility in a ich serves no more than ose primary diagnoses is y also have other dult clients or three minor y diagnoses is lities but may also have live with a family and the ervice. This facility shall be wing rules: 10A NCAC 27G	V 289			
	facility failed to ensur	ews and interviews, the e that services were only fecting 2 of 3 clients (#1 &				
		1 of the facility's Division of ation licensure documents				

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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		' '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			
		MHL049-145	B. WING		1	1/17/2021
		1	<b> </b>			1/11/2021
NAME OF P	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE			
THE GRO	VE		ESTNUT GROVE RO	DAD		
			SVILLE, NC 28625			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
V 289	order to provide time older than 18.  - There were no curred with the service reached the age of a service reached the service reach	tained waivers in the past in e-limited services to clients  rent waivers for Client #1 or es at the facility after they 18.  021 and 11/15/2021 of Client d: 13/2021 ate Intellectual Disabilities; sorder; Neurofibromatosis, at causes tumors to form on d spinal column); PICA ms); Constipation; and	V 289			
	#3's record revealed - Admission date: 4/ - Diagnoses: Autism intellectual disability with right estopia (st both eyes turn inwar Atrophy; Gastrostom Extreme immaturity Age: 18 years, 10 Interview on 11/17/2 revealed: - When Client #3 was facility, she was told that he could remain if he continued to att - Client #3 was atte each week She had not been in the continued to the continued to attent week.	1/2020. 1 Spectrum Disorder; Mild 1; Cerebral Palsy; Strabismus 1;				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		MHL049-145	B. WING		11/17	7/2021
NAME OF PI	NAME OF PROVIDER OR SUPPLIER STREET A			TE, ZIP CODE		
THE GROVE 247 CHEST		TNUT GROVE I LLE, NC 28625				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
V 289	Continued From page facility beyond his 18th Interviews on 11/16/2 Qualified Professiona - Client #1 had been shis mother's home be placement did not occided to leave him - Referrals to other resent out for Client #1, contacted had express Client #1 She had started wor Client #3 had already - There were not curres #1 and #3 that she was - She had never request to continue providing minors for clients who - She thought that the responsible for requesclients who could not placements before the Interview on 11/17/20 revealed: - She had started in the within the past year She had not seen an	h birthday.  221 and 11/17/2021 with the I (QP) revealed: scheduled for discharge to fore he turned 18, but that cur because his mother at the facility. sidential providers had been but none of the facilities sed interest in admitting king at the facility after turned 18. ently any waivers for Clients as aware of. ested a waiver from DHSR services at a facility for were turning 18. QP would be the staff sting waivers from DHSR for be transferred to adult	V 289		KATE	DATE
	- She had any conver	sations about Client #3 he facility until he was 21.				

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STATE FORM 6899 0LXQ11 If continuation sheet 9 of 9