Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
ANDILAN	or connection	IDENTIFICATION NOIMBEN.	A. BUILDING:		COMIT LETED	
		MHL001-259	B. WING		12/13/2021	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
A MOTHE	A MOTHER'S LOVE					
			ON, NC 2721			
(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 APPROPE DEFICIENCY)	BE COMPLETE	
V 000	INITIAL COMMENTS		V 000			
	on December 13, 202	aint survey was completed 21. The complaint (intake ostantiated. Deficiencies				
	category: 10A NCAC	d for the following service 27G. 1300 t for Children or Adolescents				
V 112	27G .0205 (C-D) Assessment/Treatme	nt/Habilitation Plan	V 112			
	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.					

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

(X6) DATE TITLE

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COMPLETED		
	MHL001-259		B. WING		12/13/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
A MOTUE	DIO 1 01/E	1227 WES1	MORLAND DI	RIVE		
A MOTHE	R'S LOVE	BURLINGT	ON, NC 27215	5		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)  BY TAG  ID  PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD BE  TAG  CROSS-REFERENCED TO THE APPROPRIATE  DEFICIENCY)			BE COMPLETE		
V 112	Continued From page	<u>.</u> 1	V 112			
	This Rule is not met Based on record reviet failed to assure one or client's (#1) treatment updated at least annual Review on 12/13/21 or revealed: -She was admitted or - diagnoses of Attention Oppositional Defiant I revealed a treatment of 3/24/20.  During interview on 1 confirmed;	as evidenced by: ew and interview, the facility of three t plans were reviewed and ually. The findings are: of client #1's record in 10/24/18 on Deficit Disorder and Disorder. Further review plan with an expiration date				

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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	
		MHL001-259	B. WING		12/13/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	E, ZIP CODE		
A MOTHE	R'S LOVE		STMORLAND DR GTON, NC 27215			
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE	
V 112	Continued From page	÷ 2	V 112			
	Based on record reviews and interviews the facility failed to develop and implement strategies to address elopement affecting one of one current clients (#1). The findings are:  Review on 6/18/2020 of client #1's record revealed: - Admission date of 12/28/18 Diagnosis of Schizophrenia - Treatment Plan dated 4/23/19. Further review revealed client #1's plan did not include interventions nor strategies to address his behaviors of elopement.  Review on 7/13/2020 of staff #1's record revealed: - Hire date of 11/27/09.					
	Review on 7/13/2020 revealed: - Hire date of 8'20.	of staff #2's record				
	6/26/20 revealed: "[client #1] acting out 8:21am. They talked help they picked her u	of an incident report dated we called the police at to [client #1]. She needs up and she was hopitalized." of an incident report dated				
	"Around 1:00pm [clien	nt #1] called the [police talked to [client #1]. She				

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6/30/20 revealed:

Review on 7/17/2020 of an incident report dated

"[client #1] was argue with her roomate [roomate]

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLI/ AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COMP	LETED		
		MHL001-259	B. WING		12/	12/13/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE			
A MOTUE	DIO I OVE	1227 WES	TMORLAND DI	RIVE			
A MOTHE	K S LUVE	BURLING	TON, NC 27215	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 CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE	
V 112	Continued From page	÷ 3	V 112				
V 112	and forward, so I aske and they did for a few called [roomate] a cushurt [roomate] so I go supervisor and repeat group home and my seed and how to handled buring an interview of Professional stated:  - "[client #1] should have them she needed mother the following behavitelopement, and many:  - "When she is hospited facility with no other interventions, but was unable safeguard client #1's.  - "It's not my business about the strategies for No treatment team in strategies.  - She was unable to extreatment plan did not interventions, and strategies for the strategies.  During an interview of Manager stated:	ey both was arguing back ed them both to calm down minutes. Then [client #1] es word and said she word to on the phone and call my t what was going on at the supervisor told me what to the situation."  In 7/1/2020 the Qualified  ave been gone. I've told re resources." ors: verbal aggression, hospitalizations. alized she returns to the interventions." In developing treatment to explain interventions to behaviors. Es. You need to talk to them or her." meetings to discuss explain why client #1's thave any goals, ategies to address her ent and frequent  In 7/1/2020 the House client #1 had behaviors of	V 112				
	- "We are in the proce guardianship changed more services for her - She confirmed no m treatment strategies a	d, which hopefully allow ." eetings to discuss					

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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	
		MHL001-259	B. WING		12	2/13/2021
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  1227 WESTMORLAND DRIVE  BURLINGTON, NC 27215						
(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 C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
V 112	- She confirmed an ap hospitalizations within meetings with the hos discuss appropriate in	oproximately 4 the past months. No pital prior to discharge to	V 112			

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