Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	mhl007-058	A. BUILDING: ______ B. WING ______	R 01/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY LIVING GUEST HOME #5	204 STEWART DRIVE WASHINGTON, NC 27889

(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 January 18, 2022. A deficiency was cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities. The survey sample consisted of audits of 3 current clients.	V 000	V736 - Client #1 & #3 ceiling will be repaired within 60 days. Peeling paint from top of tub will be scraped and repainted within 60 days or replaced with more durable material such as FRP. Client #2's dresser will be repaired and missing knob replaced within 60 days of exit interview. Client #5's ceiling fan lights will be replaced or the fan replaced if the issue is with the fan. Missing closet knob will be replaced within 60 days.	
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 was not maintained in a safe, clean, attractive and orderly manner. The findings are: Observation on 01/18/22 at approximately 12:15pm revealed: -Client #1 and client #3 had an approximate 2 1/2 foot crack in the ceiling and paint was peeing from the ceiling at the entrance of their bedroom; paint was peeling from the wall around the top of the shower/tub in client #1 and #3's bathroom. -Client #2 had a 6 drawer dresser and the right bottom was missing a knob, four dresser drawers were off track. -Client #5's bedroom had a 4 light ceiling fan with	V 736		

Division of Health Service Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature]

TITLE: Administrator

(X6) DATE: 1/27/22

DHSR - Mental Health
JAN 31 2022
Lic. & Cert. Section

Division of Health Service Regulation

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COUNTRY LIVING GUEST HOME #5	204 STEWART DRIVE WASHINGTON, NC 27889

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V 736	Continued From page 1 2 lights that had not worked, the closet door was missing a knob on the right side. -Client #4's closet was missing a knob on the right side. Interview on 1/18/22 the Quality Assurance staff stated: -The ceiling in client #1 and client #3's bedroom was scheduled to be repaired soon. Interview on 1/18/22 the Qualified Professional stated he understood the facility was required to maintain a safe, attractive and orderly manner.	V 736		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
mhl007-058 (Y1)	A. Building B. Wing (Y2)	1/18/2022 (Y3)

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY LIVING GUEST HOME #5	204 STEWART DRIVE WASHINGTON, NC 27889

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix V0118 Reg. # 27G .0209 (C) LSC	Correction Completed 01/18/2022	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
			Latisha Grant	1-18-22
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO
7/31/2019	

EVENT ID: 245G12

NC DEPARTMENT OF
HEALTH AND HUMAN SERVICES

ROY COOPER • Governor
KODY H. KINSLEY • Secretary
MARK PAYNE • Director, Division of Health Service Regulation

January 24, 2022

Ms. Kellie Hardison, Director
Country Living Guest Home, Inc
204 Stewart Drive
Washington, NC 27889

Re: Annual and Follow Up Survey completed 1/18/22
Country Living Guest Home #5, 204 Stewart Drive, Washington, NC, 27889
MHL # 007-058
E-mail Address: countrylivinginc@yahoo.com

Dear Ms. Hardison:

Thank you for the cooperation and courtesy extended during the annual and follow up survey completed 1/18/22.

As a result of the follow up survey, it was determined that the deficiency is now in compliance, which is reflected on the enclosed Revisit Report. A deficiency was cited during the survey.

Enclosed you will find all deficiencies cited listed on the Statement of Deficiencies Form. The purpose of the Statement of Deficiencies is to provide you with specific details of the practice that does not comply with state regulations. You must develop one Plan of Correction that addresses each deficiency listed on the State Form, and return it to our office within ten days of receipt of this letter. Below you will find details of the type of deficiencies found, the time frames for compliance plus what to include in the Plan of Correction.

Type of Deficiencies Found

- Standard level deficiency

Time Frames for Compliance

- Standard level deficiency must be ***corrected*** within 60 days from the exit of the survey, which is March 19, 2022.

What to include in the Plan of Correction

- Indicate what measures will be put in place to ***correct*** the deficient area of practice (i.e. changes in policy and procedure, staff training, changes in staffing patterns, etc.).
- Indicate what measures will be put in place to ***prevent*** the problem from occurring again.
- Indicate ***who will monitor*** the situation to ensure it will not occur again.
- Indicate ***how often*** the monitoring will take place.
- Sign and date the bottom of the first page of the State Form.

Make a copy of the Statement of Deficiencies with the Plan of Correction to retain for your records. ***Please do not include confidential information in your plan of correction and please remember never to send confidential information (protected health information) via email.***

Send the original completed form to our office at the following address within 10 days of receipt of this letter.

Mental Health Licensure and Certification Section
NC Division of Health Service Regulation
2718 Mail Service Center
Raleigh, NC 27699-2718

A follow up visit will be conducted to verify all violations have been corrected. If we can be of further assistance, please call Ms. Gloria Locklear, Team Leader at (910) 214-0350.

Sincerely,

Latisha Grant

Latisha Grant
Facility Compliance Consultant I
Mental Health Licensure & Certification Section

Cc: Leza Wainwright, Director, Trillium Health Resources LME/MCO
Fonda Gonzales, Interim Quality Management Director, Trillium Health Resources LME/MCO
Pam Pridgen, Administrative Assistant