STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		A. BUILDING:			
	MHL060-166	B. WING		03	R 3/09/2022
ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE,	ZIP CODE		
	5215 PI	NEBROOK DRIVE			
	E CHARLO	OTTE, NC 28208			
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETI DATE
INITIAL COMMENTS	3	V 000			
category: 10A NCAC Living for Adults Who	27G 5600C Supervised se primary Diagnosis is a				
The survey sample c	onsisted of 3 current clients.				
27G .5603 Supervise	d Living - Operations	V 291			
 (a) Capacity. A facilist clients when the ordevelopmental disability on June 15, 2001, and than six clients at that provide services at maintained between a qualified professional treatment/habilitation (c) Participation of the Responsible Person. provided the opportune relationship with her of means as visits to the facility. Reports a substantial progress toward means (d) Program Activities activity opportunities 	ity shall serve no more than clients have mental illness or ilities. Any facility licensed of providing services to more t time, may continue to o more than the facility's ation. Coordination shall be the facility operator and the s who are responsible for or case management. The Family or Legally Each client shall be nity to maintain an ongoing or his family through such e facility and visits outside shall be submitted at least t of a minor resident, or the erson of an adult resident. riting or take the form of a focus on the client's sting individual goals. s. Each client shall have based on her/his choices,				
	signed to foster community				
	ROVIDER OR SUPPLIER DK DRIVE GROUP HOM SUMMARY ST (EACH DEFICIENC REGULATORY OR INITIAL COMMENTS An annual and follow Deficiencies were cite This facility is license category: 10A NCAC Living for Adults Who Developmental Disat The survey sample c 27G .5603 Supervise 10A NCAC 27G .560 (a) Capacity. A facili six clients when the c developmental disabi on June 15, 2001, and than six clients at tha provide services at maintained between qualified professional treatment/habilitation (c) Participation of the Responsible Person. provided the opportun- relationship with here means as visits to the the facility. Reports a annually to the paren- legally responsible per- Reports may be in we conference and shall progress toward mee- (d) Program Activities needs and the treatment- activity opportunities needs and the treatment- activity opportunities needs and the treatment- provide and the treatment- activity opportunities needs and the treatment- ac	F CORRECTION IDENTIFICATION NUMBER: MHL060-166 MHL060-166 SUVIDER OR SUPPLIER STREET A DX DRIVE GROUP HOME S215 PIN CHARLO SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) INITIAL COMMENTS An annual and follow up survey was completed. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G 5600C Supervised Living for Adults Whose primary Diagnosis is a Developmental Disability. The survey sample consisted of 3 current clients. 27G .5603 Supervised Living - Operations 10A NCAC 27G .5603 OPERATIONS (a) Capacity. A facility shall serve no more than six clients when the clients have mental illness or developmental disabilities. Any facility licensed on June 15, 2001, and providing services to more than six clients at that time, may continue to provide services at no more than the facility's licensed capacity. (b) Service Coordination. Coordination shall be maintained between the facility operator and the qualified professionals who are responsible for treatment/habilitation or case management. (c) Participation of the Family or Legally Responsible Person. Each client shall be provided the opportunity to maintain an ongoing relationship with her or his family through such means as visits to the facility and visits outside the facility. Reports shall be submitted at least annually to the parent of a minor resident, or the legally responsible person of an adult resident. Reports may be in writing or take the form of a conference and shall focus on the client's progress toward meeting individual goals. (d) Program Activities. Each client shall have activity opportunities based on her/his choices, needs and the treatment/habilitation plan.	F CORRECTION IDENTIFICATION NUMBER: A. BUILDING: MHL060-166 B. WING COVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, DX DRIVE GROUP HOME STREET ADDRESS, CITY, STATE, SUMMARY STATEMENT OF DEFICIENCIES ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID INITIAL COMMENTS V 000 An annual and follow up survey was completed. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G 5600C Supervised Living for Adults Whose primary Diagnosis is a Developmental Disability. V 291 10A NCAC 27G .5603 OPERATIONS (a) Capacity. A facility shall serve no more than six clients when the clients have mental illness or developmental disabilities. Any facility licensed on June 15, 2001, and providing services to more than six clients at that time, may continue to provide services at no more than the facility's licensed capacity. (b) Service Coordination. Coordination shall be maintained between the facility operator and the qualified professionals who are responsible for treatment/habilitation or case management. (c) Participation of the Family or Legally Responsible Person. Each client shall be provide services the facility on visits outside the facility. Reports shall be submitted at least annually to the parent of a minor resident, or the legally responsible person of an adult resident. Reports may be in writing or take the form of a conference and shall focus on the client's progress toward meeting individual goals.	F CORRECTION IDENTIFICATION NUMBER: A BUILDING: MHL060-166 B. WING DOVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE SC DRIVE GROUP HOME STREET ADDRESS, CITY, STATE, ZIP CODE SUMMARY STATEMENT OF DEFICIENCY PREPIX REGULATORY OR LISE IDENTIFYING INFORMATION PREPIX REGULATORY OR LISE IDENTIFYING INFORMATION PREPIX INITIAL COMMENTS V 000 An annual and follow up survey was completed. DEFICIENCI Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G 5600C Supervised Living or Adults Whose primary Diagnosis is a Developmental Disability. V 291 The survey sample consisted of 3 current clients. Z7G 5603 OPERATIONS V 291 10A NCAC 27G 5603 OPERATIONS V 291 U 291 10A NCAC 27G 503 OPERATIONS V 291 U 291 10A NCAC 27G 503 OPERATIONS V 291 U 291 (c) Service Coordination. Any facility island serve no more than six clients when the clients have mental illness or developmental disabilities. Any facility island serve no more than six clients when the facility or tageally E Coordination shall be maintained between the facility or tageally (c) Participation of the Family or Leg	F CORRECTION INTERCATION NUMBER: A BUILDING: COM MHL060-166 B. WING 02 COMDER OR SUMPLIER STREET ADDRESS, CITY, STATE, ZIP CODE CHARLOTTE, NC 2320 CONDER OR SUMPLIER SUMMARY STATEMENT OF DEFICIENCIES CHARLOTTE, NC 23203 COMMARY STATEMENT OF DEFICIENCIES CHARLOTT, NC 23203 COMMARY STATEMENT, NC OF DEFICIENCIES CHARLOTT, NC 23203 COMMARY STATEMENT, NC OF DEFICIENCIES CHARLOTT, NC 23203 COMMARY STATEMENT, NC OF DEFICIENCIES CHARLOTT, NC 2320 COMMARY STATEMENT, NC OF DEFICIENCIES CHARLOTT, NC 2320 COMMARY STATEMENT, NC 2000 COMMARY STATEMEN

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			B. WING			R
		MHL060-166			03	/09/2022
AME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE, EBROOK DRIVE	ZIP CODE		
INEBRO	OK DRIVE GROUP HOM	F	OTTE, NC 28208			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLE DATE
V 291	Continued From page 1		V 291			
		nay be limited when the court olved or when health or e a primary concern.				
	facility failed to maint facility operator and t responsible for the cl	as evidenced by: ews and interview, the ain coordination between the the professionals who are ient's treatment affecting 3 of #3). The findings are:				
	signed 6-23-21 revea	essure monthly, notify nurse				
	Administration Recor					
	revealed: -No documentati	electronic notes for Client #1 ion of the nurse being notified gher than the accepted				
	signed 6-23-21 revea	essure daily, notify nurse if				
	Administration Recor	Client #2's MAR (Medication d) for January, February and 2's Blood Pressure checks:				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			
		MHL060-166	B. WING		R 03/09/2022	
NAME OF PI	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE,	, ZIP CODE		
INEBRO	OK DRIVE GROUP HOM	ME	NEBROOK DRIVE OTTE, NC 28208			
	SUMMARY S			PROVIDER'S PLAN OF	CORRECTION	(XE)
(X4) ID PREFIX TAG	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
V 291	Continued From pag	ge 2	V 291			
	-1-3-22 147/94,					
	- 1-4-22 143/83					
	-1-7-22 142/80,					
	-1-8-22 168/85,					
	-1-9-22 157/84,					
	-1-11-22 145/86					
	-1-12-22 168/98	3,				
	-1-13-22 149/89	Э,				
	-1-14-22 167/97	7,				
	-1-16-22 145/95	5,				
	-1-7-22 163/96,					
	-1-18-22 148/89	Э,				
	-1-19-22 150/87	7,				
	-1-20-22 150/90),				
	-1-21-22 157/90),				
	-1-22-22, 154/8					
	-1-23-22 170/94					
	-1-24-22 148/80	-				
	-1-25-22 143/85					
	-1-26-22 149/82					
	- 1-29-22 142/8					
	-1-30-22 160/9					
	- 1-31-22 149/8					
	-2-1-22 155/85					
	-2-4-22 152/89					
	-2-5-22 1658/8 - 2-8-22 145/89					
	-2-9-22 145/89					
	- 2-12-22 141/89					
	-2-12-22 143/6					
	-2-14-22 148/8					
	-2-15-22 143/8					
	-2-16-22 150/7					
	-2-18-22 163/9	-				
	-2-20-22 160/8					
	-2-21-22 144/88					
	-2-25-22 142/81					
	-2-26-22 153/95					
	-2-27-22 166/10	-				
	-2-28-22 155/91					

STATE FORM

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If continuation sheet 3 of 5

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		MHL060-166	B. WING		03	R / /09/2022
IAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	ZIP CODE		
		5215 PIN	IEBROOK DRIVE			
INEBRO	OK DRIVE GROUP HOM	CHARLC	DTTE, NC 28208			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE
V 291	Continued From page	e 3	V 291			
	revealed: -No documentat	electronic notes for Client #2 ion of the nurse being notified gher than the accepted				
	Review on 3-8-22 of Client #3's Physician order signed 6-23-21 revealed: -Check Blood pressure weekly, notify nurse if over 140/90 or under 60/90.					
	Administration Recor	3, 3, 2, 0,				
	revealed: -No documentat	electronic notes for Client #3 ion of the nurse being notified gher than the accepted				
	revealed: -The staff are su the T log (electronic - 166 is not strok blood pressure is tak medicine is given and	ke level. Most of the time the en before the blood pressure				

STATE FORM

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Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CC		(X3) DATE SURVEY COMPLETED			
		IDENTIFICATION NOMBER.	A. BUILDING:		COM		
		MHL060-166	B. WING		03	R 3/ 09/2022	
AME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	ZIP CODE			
INEBRO	OK DRIVE GROUP HOM	F	NEBROOK DRIVE DTTE, NC 28208				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE	
V 291	Continued From page 4		V 291				
	reason to look at it. -"That is the reason putting it in the T log. Interview on 3-8-22 w revealed: -Staff does notify -She was looking staff had called the n -She had been t 2021. -She had been so other facility. but was facility. -She will definite	g for documentation that the urse but couldn't find any. he manager since November spending a lot of time at her a now concentrating on this ely be implementing protocol nent when they call the nurse					

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