

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>mhl096-192</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>03/30/2022</b>
NAME OF PROVIDER OR SUPPLIER  <b>ASA LIVING I</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1308 BEN BREWINGTON DRIVE GOLDSBORO, NC 27530</b>		
(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 March 30, 2022. Deficiencies were cited.  This facility is licensed for the following service category: 10A NCAC 27G .5600A Supervised Living for Adults with Mental Illness.  This facility is licensed for 4 and currently has a census of 2. The survey sample consisted of audits of 2 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		

Division of Health Service Regulation

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

TITLE

(X6) DATE

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>mhl096-192</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____		(X3) DATE SURVEY COMPLETED  <b>R</b> <b>03/30/2022</b>
NAME OF PROVIDER OR SUPPLIER  <b>ASA LIVING I</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1308 BEN BREWINGTON DRIVE</b> <b>GOLDSBORO, NC 27530</b>		
(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 112	<p>Continued From page 1</p> <p>This Rule is not met as evidenced by: Based on record review and interview the facility failed to implement strategies in a Treatment Plan for one of two clients (#1). The findings are:</p> <p>Review on 03/20/22 of client #1's record revealed: -46 year old male. -Admission date of 09/15/09. -Diagnosis of Schizophrenia.</p> <p>Review on 03/20/22 of client #1's Person-Centered Plan dated 07/29/21 revealed: -"[Client #1] is authorized 40 hours per month of unsupervised time."</p> <p>During interview on 03/20/22 client #1 revealed: -Every day he leaves the facility on his bicycle at approximately 9:00am and would return to the facility at approximately 2:00pm. -He would go to the local fast food restaurant and to the activity center to hang out with friends. -He was always unsupervised during that time.</p> <p>During interview on 03/20/22 staff #1 revealed: -Client #1 had unsupervised time during the day. -Client #1 would leave the facility in the morning around 9:00am and return to the facility at 2:00pm. -He would speak with the Qualified Professional to ensure his treatment plan indicated the appropriate times for his unsupervised time in the community.</p>	V 112			

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>mh1096-192</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>03/30/2022</b>
NAME OF PROVIDER OR SUPPLIER  <b>ASA LIVING I</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1308 BEN BREWINGTON DRIVE GOLDSBORO, NC 27530</b>		
(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 289	<p>27G .5601 Supervised Living - Scope</p> <p>10A NCAC 27G .5601 SCOPE</p> <p>(a) Supervised living is a 24-hour facility which provides residential services to individuals in a home environment where the primary purpose of these services is the care, habilitation or rehabilitation of individuals who have a mental illness, a developmental disability or disabilities, or a substance abuse disorder, and who require supervision when in the residence.</p> <p>(b) A supervised living facility shall be licensed if the facility serves either:</p> <p>(1) one or more minor clients; or</p> <p>(2) two or more adult clients.</p> <p>Minor and adult clients shall not reside in the same facility.</p> <p>(c) Each supervised living facility shall be licensed to serve a specific population as designated below:</p> <p>(1) "A" designation means a facility which serves adults whose primary diagnosis is mental illness but may also have other diagnoses;</p> <p>(2) "B" designation means a facility which serves minors whose primary diagnosis is a developmental disability but may also have other diagnoses;</p> <p>(3) "C" designation means a facility which serves adults whose primary diagnosis is a developmental disability but may also have other diagnoses;</p> <p>(4) "D" designation means a facility which serves minors whose primary diagnosis is substance abuse dependency but may also have other diagnoses;</p> <p>(5) "E" designation means a facility which serves adults whose primary diagnosis is substance abuse dependency but may also have other diagnoses; or</p> <p>(6) "F" designation means a facility in a</p>	V 289		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>mhl096-192</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>03/30/2022</b>
NAME OF PROVIDER OR SUPPLIER  <b>ASA LIVING I</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1308 BEN BREWINGTON DRIVE GOLDSBORO, NC 27530</b>		
(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 289	<p>Continued From page 3</p> <p>private residence, which serves no more than three adult clients whose primary diagnoses is mental illness but may also have other disabilities, or three adult clients or three minor clients whose primary diagnoses is developmental disabilities but may also have other disabilities who live with a family and the family provides the service. This facility shall be exempt from the following rules: 10A NCAC 27G .0201 (a)(1),(2),(3),(4),(5)(A)&amp;(B); (6); (7) (A),(B),(E),(F),(G),(H); (8); (11); (13); (15); (16); (18) and (b); 10A NCAC 27G .0202(a),(d),(g)(1) (i); 10A NCAC 27G .0203; 10A NCAC 27G .0205 (a),(b); 10A NCAC 27G .0207 (b),(c); 10A NCAC 27G .0208 (b),(e); 10A NCAC 27G .0209[(c)(1) - non-prescription medications only] (d)(2),(4); (e) (1)(A),(D),(E);(f);(g); and 10A NCAC 27G .0304 (b)(2),(d)(4). This facility shall also be known as alternative family living or assisted family living (AFL).</p> <p>This Rule is not met as evidenced by: Based on record reviews and interview, the facility failed to meet the scope of a 5600A facility which serves adults whose primary diagnosis is mental illness for 1 of 2 clients (#2). The findings are:</p> <p>Review on 03/29/22 of the facility's license issued by the Division of Health Service Regulation (DHSR) revealed the facility was licensed to provide services for adults whose primary diagnosis was mental illness.</p> <p>Review on 03/30/22 of client #2's record revealed:</p>	V 289		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>mhl096-192</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____		(X3) DATE SURVEY COMPLETED  <b>R</b> <b>03/30/2022</b>
NAME OF PROVIDER OR SUPPLIER  <b>ASA LIVING I</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1308 BEN BREWINGTON DRIVE</b> <b>GOLDSBORO, NC 27530</b>		
(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 289	<p>Continued From page 4</p> <p>-64 year old male.</p> <p>-Diagnoses of Hypertension, Hypercholesterolemia, Gastroesophageal reflux disease.</p> <p>-No psychotropic medications.</p> <p>During interview on 03/30/22 staff #1 revealed:</p> <p>-The Qualified Professional was working on a waiver for client #2.</p> <p>-He would talk with the Qualified Professional when she got off work and to get the status of the waiver.</p>	V 289			