| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL080-222 | | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED | |
|---|--|---|---|---|-------------------------------|--------------------------|
| | | | | | | |
| | | B. WING | | R 04/20/2022 | | |
| NAME OF PI | ROVIDER OR SUPPLIER | STREET A | DDRESS, CITY, STATE | , ZIP CODE | | |
| REVIVE H | OUSING, LLC | | TH LONG STREET | | | |
| | | | JRY, NC 28144 | | | |
| (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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY) | OULD BE | (X5) COMPLETI DATE |
| ∨ 000 | INITIAL COMMENTS | | V 000 | | | |
| | A follow up survey was completed on 4-20-22. Deficiencies were cited. | | | | | |
| | | ed for the following service 27G 1700 Residential are for Children and | | | | |
| | | ed for four and currently has survey sample consisted of | | | | |
| V 296 | 27G .1704 Residenti Staffing | al Tx. Child/Adol - Min. | V 296 | | | |
| | telephone or page. A | 4 MINIMUM STAFFING ssional shall be available by A direct care staff shall be lity within 30 minutes at all | | | | |
| | required when childre present and awake is (1) two direct of | mber of direct care staff en or adolescents are s as follows: care staff shall be present for ur children or adolescents; | | | | |
| | (2) three direct for five, six, seven or adolescents; and | care staff shall be present | | | | |
| | nine, ten, eleven or to adolescents. | - | | | | |
| | follows: | scent sleep hours is as care staff shall be present | | | | |
| | and one shall be awa children or adolescer | ake for one through four | | | | |
| isian of Llos | (2) two direct of alth Service Regulation | are stall shall be present | | | | |

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| Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MULTIPLE CO | | (X3) DATE SURVEY COMPLETED | | |
|---|--|---|----------------------------------|---|--|-----------------------|
| | | | A. BUILDING: | | | |
| | | MHL080-222 | B. WING | | 04 | R 1/20/2022 |
| NAME OF P | ROVIDER OR SUPPLIER | STREET A | ADDRESS, CITY, STATE | ZIP CODE | | |
| REVIVE H | OUSING, LLC | | RTH LONG STREET URY, NC 28144 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN O (EACH CORRECTIVE AG CROSS-REFERENCED TO DEFICIEN | CTION SHOULD BE COMPLE O THE APPROPRIATE DATE | |
| V 296 | Continued From page | e 1 | V 296 | | | |
| | children or adolescer (3) three direct of which two shall be asleep for nine, ten, or adolescents. (d) In addition to the care staff set forth in Rule, more direct car the facility based on the individual needs as splan. (e) Each facility shall supervision of children are away from the facility for the facility shall supervision of children are away from the facility for the facility for the facility shall supervision for the facility for the facility for the facility shall supervision of children are away from the facility for the facility facility for the facility facility facility for the facility fac | a care staff shall be present awake and the third may be eleven or twelve children or minimum number of direct Paragraphs (a)-(c) of this re staff shall be required in the child or adolescent's pecified in the treatment I be responsible for ensuring en or adolescents when they cility in accordance with the individual strengths and | | | | |
| | failed maintain minim | as evidenced by: n and interviews the facility num staffing requirements of ents. The findings are: | | | | |
| | revealed: -Staff #1 opening surveyor in. -Staff #2 pulling | -22 at approximately 1:00 pm g the facility door to let into the driveway will fast | | | | |
| | -There were usu | with Client #1 revealed: ally two staff working. n" that one staff was there by | | | | |

STATE FORM

IISX11

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| Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CO | | | (X3) DATE SURVEY | |
|---|---|---|---------------------|--|--|--|
| AND PLAN OF CORRECTION IDENTIFICATION NUMBER: MHL080-222 | | IDENTIFICATION NUMBER. | A. BUILDING: | | COMPLETED | |
| | | B. WING | | | R 04/20/2022 | |
| AME OF PF | ROVIDER OR SUPPLIER | STREET A | DDRESS, CITY, STATE | , ZIP CODE | | |
| EVIVE H | OUSING, LLC | | TH LONG STREET | | | |
| | | | JRY, NC 28144 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN C (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIEI | CTION SHOULD BE COMPLE D THE APPROPRIATE DATE | |
| V 296 | Continued From page | 2 | V 296 | | | |
| | -Staff will run dow to get a drink. -They are only ge -It does not happ Interview on 4-19-22 -It was her fourth -it was two staff v gone for a few minute -"We are not sup -This was the firs by herself. Interview on 4-19-22 -He had left to ge | with Staff #1 revealed: a day at the facility. working, but Staff #2 had es. posed to leave." at time Staff #2 had left her with Staff #2 revealed: | | | | |
| | | , I didn't see a problem, but o together, or whenever one where." | | | | |
| | facility and would be a him. | | | | | |
| | of the fact that Staff # | t1 was new. we sure all staff knew that | | | | |
| | Ith Service Regulation | | | | | |

IISX11