	IT OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMPI	
		MHL001-083	B. WING		04/1	R 3/2022
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
CEDARS	DDA GROUP HOME	838 ROSS BURLING	S STREET TON, NC 27	217		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	_D BE	(X5) COMPLETE DATE
V 000	INITIAL COMMENT	-S	V 000			
	on 4/13/22. Deficier	w up survey was completed noies were cited.				
	category: 10A NCA	C 27G .5600C Supervised h Developmental Disability.				
		sed for 8 and currently has a urvey sample consisted of clients.				
V 112	27G .0205 (C-D) Assessment/Treatn	nent/Habilitation Plan	V 112			
	PLAN (c) The plan shall b	05 ASSESSMENT AND LITATION OR SERVICE be developed based on the partnership with the client or				
	legally responsible	person or both, within 30 days ents who are expected to yond 30 days.				
	achieved by provision projected date of action (2) strategies;					
	annually in consultaresponsible person	review of the plan at least tion with the client or legally				
	outcome achieveme (6) written consent responsible party, o provider stating why					
	obtained.					

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

AND DUAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
			B. WING		R	
		MHL001-083	D. WINO		04/1	3/2022
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
CEDARS	DDA GROUP HOME	838 ROSS BURLING	STREET TON, NC 27	217		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON	(X5)
PRÉFIX TAG		MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)		COMPLETE DATE
V 112	Continued From pa	ge 1	V 112			
V 114	the facility failed to a least annually affect. The findings are: Review on 4/12/22 of annually affect. The findings are: Review on 4/12/22 of annual annu	view and interview, the facility schedule a review of a plan at ting one of three clients (#3). of client #3's record revealed: 10/29/12. ectual and Developmental ed, Schizophrenia, Dementia, pnea and Psoriasis. Plan (PCP) dated 9/7/20. umentation that client #3 had a 2021. with the Manager revealed: e PCP for client #3 was not acility failed to schedule a east annually for client #3. ncy Plans and Supplies of EMERGENCY PLANS in for each facility and clan shall be developed and by the appropriate local e made available to all staff cedures and routes shall be	V 114			

Division of Health Service Regulation

STATE FORM 6899 12S611 If continuation sheet 2 of 10

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED	
	MHL001-083		B. WING			R 13/2022
	PROVIDER OR SUPPLIER B DDA GROUP HOME	838 ROSS	, ,	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI- CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
V 114	(c) Fire and disaste shall be held at leas repeated for each s under conditions the	ge 2 r drills in a 24-hour facility st quarterly and shall be hift. Drills shall be conducted at simulate fire emergencies. Ill have basic first aid supplies	V 114			
	facility failed to condunder conditions the findings are: Review on 4/13/22 revealed: -3/14/22-9:30 pm -11/10/21-5:30 pm -7/14/21-11 pm -6/16/21-6:45 am -There was no dock doing a drill during the doing th	et as evidenced by: view and interviews, the duct fire and disaster drills at simulate emergencies. The of the facility's fire drill log umentation of 8am-8pm staff the 1st quarter of 2022. umentation of 8pm-8am staff the 4th quarter of 2021. umentation of 8am-8pm staff the 3rd quarter of 2021. umentation of 8am-8pm staff the 2nd quarter of 2021. of the facility's disaster drill log umentation of 8am-8pm and/or g a drill during the 1st quarter umentation of the 8am-8pm aff doing a drill during the 4th				

Division of Health Service Regulation

STATE FORM 6899 12S611 If continuation sheet 3 of 10

NAME OF PROVIDER OR SUPPLIER CEDARS DDA GROUP HOME STREET ADDRESS, CITY, STATE, ZIP CODE 838 ROSS STREET BURLINGTON, NC 27217	I
NAME OF PROVIDER OR SUPPLIER CEDARS DDA GROUP HOME MHL001-083 B. WING	
CEDARS DDA GROUP HOME 838 ROSS STREET BURLINGTON, NC 27217	
CEDARS DDA GROUP HOME BURLINGTON, NC 27217	ZIP CODE
CAN ID STIMMARY STATEMENT OF DESICIENCIES ID DROVIDEDIS DI AN OF CORRECTION	
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COM	ROSS-REFERENCED TO THE APPROPRIATE DATE
V 114 Continued From page 3 V 114	
-There was no documentation of the 8am-8pm and/or 8pm-8am staff doing a drill during the 3rd quarter of 2021. -There was no documentation of the 8am-8pm and/or 8pm-8am staff doing a drill during the 2nd quarter of 2021 Interview on 4/12/22 with client #1 revealed: -He thought staff did fire and disaster drills with themHe thought the drills were done monthly. Interview on 4/12//22 with client #2 revealed: -He thought they did fire and disaster drills with staffHe was not sure how often staff conducted the fire and disaster drills with them. Interview on 4/12//22 with client #3 revealed: -He thought staff conducted fire and disaster drills with themHe was not sure how often the fire and disaster drills with themHe was not sure how often the fire and disaster drills were conducted. Interview on 4/13/22 with the Manager revealed: -The group home had two shifts. He worked the 8am-8pm shift. Another staff worked the 8am-8pm shift. Another staff worked the 8pm-8am shiftThe last surveyor told him he was supposed to be doing fire and disaster drills quarterlyHe didn't realize they were supposed to be doing the fire and disaster drills under conditions that simulate emergencies. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	

Division of Health Service Regulation
STATE FORM

6899 12S611 If continuation sheet 4 of 10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL001-083					(X3) DATE SURVEY COMPLETED R 04/13/2022	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
V 121	Continued From pa	ge 4	V 121			
V 121	27G .0209 (F) Med	cation Requirements	V 121			
	governing body or of for obtaining a review regimen at least even shall be to be performant of the client's physician. The ones the client's physician the review when medical the findings of the statement of the client's physician the review when medical the findings of the statement of the client's physician the review when medical the client's physician the statement of the client's physician the client's ph	w: ives psychotropic drugs, the operator shall be responsible ew of each client's drug ery six months. The review rmed by a pharmacist or ite manager shall assure that n is informed of the results of edical intervention is indicated. the drug regimen review shall client record along with				
	facility failed to obta months for three of	et as evidenced by: views and interview, the ain drug reviews every six three clients (#1, #2 and #3) notropic drugs. The findings				
	revealed: -Admission date of -Diagnoses of Para Intellectual and Dev	noid Schizophrenia, Moderate velopmental Disability, ve Disorder and History of				
	-Order dated 4/16/2 milligrams (mg), on	of physician's orders revealed: 21 for Sertraline HCL 100 e tablet daily; Risperidone 3 e daily; Trazodone 50 mg, one				

Division of Health Service Regulation

STATE FORM 6899 12S611 If continuation sheet 5 of 10

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
['		A. BUILDING:		R		
		MHL001-083	B. WING	· · · · · · · · · · · · · · · · · · ·		3/2022
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
CEDARS	DDA GROUP HOME		S STREET TON, NC 27	217		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
V 121	tablets at bedtime; mg, two tablets at bedtime; mg, two tablets at bedtime, two tablets twice. Review on 4/13/22 Administration Rec-April 2022-Staff do administered the absolute at 4/12. Review on 4/13/22 -There was no evid psychotropic drug on the bedtime and the foliagnoses of Intell Disability-Unspecific Obstructive Sleep Active tablets daily; Questioned and the foliagnoses of Intell Disability-Unspecific Obstructive Sleep Active tablets daily; Questioned and the foliagnoses of Intell Disability-Unspecific Obstructive Sleep Active tablets daily; Questioned and the foliagnoses of Intell Disability-Unspecific Obstructive Sleep Active tablets daily; Questioned and the foliagnoses of Intell Disability-Unspecific Obstructive Sleep Active tablets daily; Questioned and the foliagnoses of Intell Disability-Unspecific Obstructive Sleep Active tablets at bedtime, and the foliagnoses of Intell Disability-Unspecific Obstructive Sleep Active tablets at bedtime, and the foliagnoses of Intell Disability-Unspecific Obstructive Sleep Active tablets at bedtime, and the foliagnoses of Intell Disability-Unspecific Obstructive Sleep Active tablets and the foliagnoses of Intell Disability-Unspecific Obstructive Sleep Active tablets and the foliagnoses of Intell Disability-Unspecific Obstructive Sleep Active tablets and the foliagnoses of Intell Disability-Unspecific Obstructive Sleep Active tablets and the foliagnoses of Intell Disability-Unspecific Obstructive Sleep Active tablets and the foliagnoses of Intell Disability-Unspecific Obstructive Sleep Active tablets and the foliagnoses of Intell Disability-Unspecific Obstructive Sleep Active tablets and the foliagnoses of Intell Disability-Unspecific Obstructive Sleep Active tablets and the foliagnoses of Intell Disability-Unspecific Obstructive Sleep Active tablets and the foliagnoses of Intell Disability-Unspecific Obstructive Sleep Active tablets and the foliagnoses of Intell Disability-Unspecific Obstructive Sleep Active tablets and the foliagnoses of Intell Disability-Unspec	laily; Trazodone 50 mg, 2 Divalproex Sodium ER 500 pedtime and Buspar HCL 15 pedaily. of the Medication ord (MAR) revealed: power medications 4/1 thru of facility records revealed: ence of a six month review for client #1. 22 of client #3's record 10/29/12. lectual and Developmental ed, Schizophrenia, Dementia, Apnea and Psoriasis. of physician's orders revealed: 1 for Sertraline HCL 100 mg, uetiapine Fumarate 100 mg, ily; Quetiapine Fumarate 400 edtime; Fluphenazine 10 mg, 1 Itime and Trazodone 100 mg, me. of the MAR revealed: coumented client #3 was bove medications 4/1 thru ecords on 4/13/22 revealed: lence of a six month	V 121			
		as supposed to come to the				

Division of Health Service Regulation STATE FORM

6899 12S611 If continuation sheet 6 of 10

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MIII 004 000	B. WING		R 04/13/2022	
		MHL001-083	D. WING	·····	04/1	3/2022
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
CEDARS	DDA GROUP HOME	838 ROSS BURLING	S STREET TON, NC 27	217		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
V 121	Continued From pa	ge 6	V 121			
	reviewHe thought the pha and did the psychot not remember the s came to the group h -He confirmed there	armacist came out last year ropic drug reviews. He could pecific date the pharmacist nome last year. e was no documentation of six or drug review for clients #1				
V 290	27G .5602 Supervis	sed Living - Staff	V 290			
	numbers specified in of this Rule shall be enable staff to responseds. (b) A minimum of copresent at all times premises, except whabilitation plan doccapable of remaining without supervision as needed but not let the client continues the home or commonspecified periods of (c) Staff shall be profollowing client-staff child or adolescent (1) children of abuse disorders shall of one staff present clients present. However, the governing body, the governing body, the staff to respect to the staff present during sleet emergency back-up the governing body.	is above the minimum in Paragraphs (b), (c) and (d) is determined by the facility to cond to individualized client one staff member shall be when any adult client is on the hen the client's treatment or cuments that the client is ig in the home or community. The plan shall be reviewed ess than annually to ensure to be capable of remaining in unity without supervision for itime. The seent in a facility in the fratios when more than one client is present: In adolescents with substance all be served with a minimum for every five or fewer minor owever, only one staff need be ping hours if specified by the procedures determined by				

Division of Health Service Regulation

STATE FORM 6899 12S611 If continuation sheet 7 of 10

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			R	
		MHL001-083	B. WING			13/2022	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
CEDARS	DDA GROUP HOME	838 ROSS BURLING	STREET TON, NC 27	217			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE	
V 290	developmental disa one staff present for present and two star more clients present du specified by the em determined by the g(d) In facilities which diagnosis is substared to the substance of the secondary complication and the service on the service of the service on the staff present and the staff present and the service of the service on the staff present and two staff	abilities shall be served with or every one to three clients aff present for every four or nt. However, only one staff uring sleeping hours if pergency back-up procedures governing body. The serve clients whose primary nee abuse dependency: The staff member who is on the din alcohol and other drug ms and symptoms of ations to alcohol and other drug the serve clients who is on the staff member who is on alcohol and other the staff member who is on alcohol and other the staff member who is on alcohol and other the staff member who is on alcohol and other the staff member who is on alcohol and other the staff member who is on alcohol and other the staff member who is on alcohol and other the staff member who is on alcohol and other the staff member who is on alcohol and other the staff member who is on alcohol and other the staff member who is on alcohol and other the staff member who is on alcohol and other the staff member who is on all the staff member who is on alcohol and other the staff member who is on all the staff	V 290				
	facility failed to revia client was capable and community with of three clients (#1) capability of having home and communaffecting one of threare: The following is evireview the plan and capable of remaining without supervision	views and interviews, the ew the plan annually to ensure e of remaining in the home nout supervision affecting one and failed to assess client's unsupervised time in the nity without staff supervision ee clients (#2). The findings dence the facility failed to hually to ensure a client was no in the home and community.					

Division of Health Service Regulation

AND DIAN OF CORRECTION . IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
MHL001-083		B. WING			⋜ 13/2022	
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
CEDARS	DDA GROUP HOME	838 ROSS	_			
	T		TON, NC 27			T
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
V 290	Continued From pa	ge 8	V 290			
	Intellectual and Dev Intermittent Explosi Fetal Alcohol Syndr -Unsupervised Time -There was no docu was reviewed annu	noid Schizophrenia, Moderate velopmental Disability, ve Disorder and History of ome. e Assessment dated 3/7/18. umentation that client #1's plan ally to ensure he was capable home and community without				
	-He had unsupervis community without -He walked through his unsupervised tir -He thought he wall 2-3 days a weekHe also stayed at t	nout the neighborhood during me in the community. Ked around the neighborhood the group home without staff to an hour a few times				
	assess client's capa	dence the facility failed to ability of having unsupervised nd community without staff				
	revealed: -Admission date of -Diagnoses of Mild Developmental Disa Disorder, Depressio -Person Centered F can have up to 2 ho walk to planned des specified amount of weekThere was no docu been assessed for	Intellectual and ability, Post Traumatic Stress on and Vitamin D Deficiency. Plan dated 7/2/21-Client #2 ours of unsupervised time to stinations and return within the f time independently 7 days a umentation that client #2 had				

Division of Health Service Regulation

STATE FORM 6899 12S611 If continuation sheet 9 of 10

NAME OF PROVIDER OR SUPPLIER CEDARS DDA GROUP HOME STREET ADDRESS, CITY, STATE, ZIP CODE BURLINGTON, NC 27217 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)	AND DUAN OF CORRECTION IDENTIFICATION NUMBER		, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 838 ROSS STREET BURLINGTON, NC 27217 [(24)] D. PROVIDERS PLAN OF CORRECTION SHOULD BE (EACH DEPCINCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) V 290 Continued From page 9 without staff supervision. Interview on 4/12/22 with client #2 revealed: -He had unsupervised time in the home and communityHe used his unsupervised time in the community to walk to the park in the neighborhood. He normally stayed at the park 1-2 hours. He wasn't sure how often he went to the parkHe used his unsupervised time at the group home sometimes. He wasn't sure how often he stayed at the gart A-2 hours. He wasn't sure how and communityHe did not realize the Unsupervised time in the home and communityHe did not realize the Unsupervised time home and communityHe did not realize the Unsupervised time home and communityHe did not realize the Unsupervised time home and communityHe confirmed the facility failed to review the plan annually. He thought once the unsupervised Time Assessment for client #2He confirmed the facility failed to review the plan annually to ensure client #1 was capable of remaining in the home and community without supervisionHe confirmed the facility failed to assess client #2's capability of having unsupervised time in the				A. BOILDING.		R	
CEDARS DDA GROUP HOME SUMMARY STATEMENT OF DEFICIENCIES BURLINGTON, NC 27217 ((A) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) V 290 Continued From page 9 without staff supervision. Interview on 4/12/22 with client #2 revealed: -He had unsupervised time in the home and communityHe used his unsupervised time in the community to walk to the park in the neighborhood. He normally stayed at the park 1-2 hours. He wasn't sure how often he stayed at the group home without staff. Interviews on 4/12/22 and 4/13/22 with the Manager revealed: -Cilents #1 and #2 had unsupervised time in the home and communityHe did not realize the Unsupervised time in the home and communityHe did not realize the unsupervised time was approved they didn't have to look at the unsupervised time again for that clientHe wasn't sure why there was no Unsupervised Time Assessment for client #1 needed to be reviewed annually. He thought once the unsupervised time was approved they didn't have to look at the unsupervised time again for that clientHe confirmed the facility failed to review the plan annually to ensure client #1 was capable of remaining in the home and community without supervisionHe confirmed the facility failed to assess client #2's capability of having unsupervised time in the			MHL001-083	B. WING	<u> </u>		
CAMPID C	NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG	CEDARS	DDA GROUP HOME	•		217		
without staff supervision. Interview on 4/12/22 with client #2 revealed: -He had unsupervised time in the home and communityHe used his unsupervised time in the community to walk to the park in the neighborhood. He normally stayed at the park 1-2 hours. He wasn't sure how often he went to the parkHe used his unsupervised time at the group home sometimes. He wasn't sure how often he stayed at the group home without staff. Interviews on 4/12/22 and 4/13/22 with the Manager revealed: -Clients #1 and #2 had unsupervised time in the home and communityHe did not realize the Unsupervised Time Assessment for client #1 needed to be reviewed annually. He thought none the unsupervised time was approved they didn't have to look at the unsupervised time again for that clientHe wasn't sure why there was no Unsupervised Time Assessment for client #2He confirmed the facility failed to review the plan annually to ensure client #1 was capable of remaining in the home and community without supervisionHe confirmed the facility failed to assess client #2's capability of having unsupervised time in the	PRÉFIX	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO	_D BE	COMPLETE
Interview on 4/12/22 with client #2 revealed: -He had unsupervised time in the home and communityHe used his unsupervised time in the community to walk to the park in the neighborhood. He normally stayed at the park 1-2 hours. He wasn't sure how often he went to the parkHe used his unsupervised time at the group home sometimes. He wasn't sure how often he stayed at the group home without staff. Interviews on 4/12/22 and 4/13/22 with the Manager revealed: -Clients #1 and #2 had unsupervised time in the home and communityHe did not realize the Unsupervised Time Assessment for client #1 needed to be reviewed annually. He thought once the unsupervised time was approved they didn't have to look at the unsupervised time again for that clientHe wasn't sure why there was no Unsupervised Time Assessment for client #2He confirmed the facility failed to review the plan annually to ensure client #1 was capable of remaining in the home and community without supervisionHe confirmed the facility failed to assess client #2's capability of having unsupervised time in the	V 290	Continued From pa	ge 9	V 290			
-He had unsupervised time in the home and community. -He used his unsupervised time in the community to walk to the park in the neighborhood. He normally stayed at the park 1-2 hours. He wasn't sure how often he went to the park. -He used his unsupervised time at the group home sometimes. He wasn't sure how often he stayed at the group home without staff. Interviews on 4/12/22 and 4/13/22 with the Manager revealed: -Clients #1 and #2 had unsupervised time in the home and community. -He did not realize the Unsupervised Time Assessment for client #1 needed to be reviewed annually. He thought once the unsupervised time was approved they didn't have to look at the unsupervised time again for that client. -He wasn't sure why there was no Unsupervised Time Assessment for client #2. -He confirmed the facility failed to review the plan annually to ensure client #1 was capable of remaining in the home and community without supervision. -He confirmed the facility failed to assess client #2's capability of having unsupervised time in the		without staff superv	rision.				
		Interview on 4/12/2He had unsuperviscommunityHe used his unsupto walk to the park normally stayed at a sure how often he was the group home sometimes. It is stayed at the group linterviews on 4/12/2. Manager revealed: -Clients #1 and #2 home and community and community. He though was approved they unsupervised time was approved they unsupervised time was approved they unsupervised time. He wasn't sure who was approved they unsupervised time. He confirmed the fannually to ensure remaining in the hosupervisionHe confirmed the fanually to capability of has	2 with client #2 revealed: sed time in the home and bervised time in the community in the neighborhood. He the park 1-2 hours. He wasn't went to the park. bervised time at the group He wasn't sure how often he home without staff. 22 and 4/13/22 with the had unsupervised time in the hity. the Unsupervised Time ent #1 needed to be reviewed int once the unsupervised time didn't have to look at the again for that client. y there was no Unsupervised for client #2. facility failed to review the plan client #1 was capable of me and community without facility failed to assess client aving unsupervised time in the				

Division of Health Service Regulation STATE FORM