PRINTED: 04/24/2022 FORM APPROVED

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				
AND FLAN OF CORRECTION		IDEITH IOMOTOMBER	A. BUILDING:						
MHL001-070		MHL001-070	B. WING		R 04/21/2022				
NAME OF P	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE								
CRESTVIEW GROUP HOME 631 CRESTVIEW DRIVE									
			TON, NC 27217		. 1				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE			
V 000	INITIAL COMMENTS		V 000						
	An annual and follow- on April 21, 2022. De	-up survey was completed ficiency cited.							
	This facility is licensed for the following service category: 10A NCAC 27G. 5600A Supervised Living for Adults with Mental Illness								
	The survey sample co current clients.	onsisted of audits of 3							
V 290	290 27G .5602 Supervised Living - Staff		V 290						
	10A NCAC 27G .5602 STAFF  (a) Staff-client ratios above the minimum numbers specified in Paragraphs (b), (c) and (d) of this Rule shall be determined by the facility to enable staff to respond to individualized client needs.  (b) A minimum of one staff member shall be present at all times when any adult client is on the premises, except when the client's treatment or habilitation plan documents that the client is capable of remaining in the home or community without supervision. The plan shall be reviewed as needed but not less than annually to ensure the client continues to be capable of remaining in the home or community without supervision for specified periods of time.  (c) Staff shall be present in a facility in the following client-staff ratios when more than one child or adolescent client is present:  (1) children or adolescents with substance abuse disorders shall be served with a minimum of one staff present for every five or fewer minor clients present. However, only one staff need be present during sleeping hours if specified by the emergency back-up procedures determined by the governing body; or  (2) children or adolescents with								

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

TITLE (X6) DATE Division of Health Service Regulation

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			A. BUILDING:					
		MHL001-070	B. WING		R <b>04/21/2022</b>			
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE				
CRESTVIE	EW GROUP HOME		VIEW DRIVE					
	BURLINGTON, NC 27217							
(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 CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE			
V 290	developmental disabilities shall be served with one staff present for every one to three clients present and two staff present for every four or more clients present. However, only one staff need be present during sleeping hours if specified by the emergency back-up procedures determined by the governing body.  (d) In facilities which serve clients whose primary diagnosis is substance abuse dependency:  (1) at least one staff member who is on duty shall be trained in alcohol and other drug withdrawal symptoms and symptoms of secondary complications to alcohol and other drug addiction; and		V 290					
	(2) the services abuse counselor shall as-needed basis for each as-need	as evidenced by: ew and interview, the facility document client's capability ed time in the home and atment plan affecting of one ts (#1). The findings are:  Client #1's record revealed: 2/3/99. phrenia, High Cholesterol,						
	GERD, Vitamin D Dei -Treatment Plan comp -There was no eviden unsupervised time in Interview on 4/19/22 v Coordinator revealed	ficiency. pleted 6/2/21. nce documenting the home or community. with the Group Home : nad unsupervised time in the						

Division of Health Service Regulation

STATE FORM 6899 NWF711 If continuation sheet 2 of 3

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Division of Health Service Regulation

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MHL001-070         B. WING         04/21/2022           NAME OF PROVIDER OR SUPPLIER         STREET ADDRESS, CITY, STATE, ZIP CODE								
CRESTVIEW GROUP HOME 631 CRESTVIEW DRIVE BURLINGTON, NC 27217								
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEI	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETE DATE		
V 290	-Client #1 had a personand the day programReported the unsuper	onal car and drove to work	V 290					

Division of Health Service Regulation

STATE FORM 6899 NWF711 If continuation sheet 3 of 3