		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
ANDILAN	OF CONTROL OF THE STATE OF THE	IDENTIFICATION NOWIDER.	A. BUILDING:		COIVII	LLILD
		MHL084-064	B. WING		04/2	7/2022
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
STARR A	APARTMENTS A B C I		THWOOD DR RLE, NC 280			
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
V 000	INITIAL COMMEN	тѕ	V 000			
	An annual survey was completed on April 27, 2022. Deficiencies were cited.					
	This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disability.					
		sed for 4 and currently has a urvey sample consisted of clients.				
V 289	27G .5601 Supervi	sed Living - Scope	V 289			
	provides residentia home environment these services is the rehabilitation of ind illness, a developm or a substance abusupervision when in (b) A supervised like the facility serves et (1) one or mode (2) two or mode (3) two or mode (4) two or mode (5) two or mode (6) two or mode (7) two or mode (8) two or mode (9) two or mode (1) two or mode (1) two or mode (1) two or mode (2) two or mode (2) two or mode (2) two or mode (3) two or mode (4) two or mode (1) two or mode (1) two or mode (2) two or mode (3) two or mode (1) tw	ng is a 24-hour facility which I services to individuals in a where the primary purpose of the care, habilitation or ividuals who have a mental tental disability or disabilities, use disorder, and who require in the residence.				

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

TITLE (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL084-064	B. WING		04/2	7/2022
NAME OF PROVIDER OR SUPPLIER STREET ADD			DRESS, CITY, S	STATE, ZIP CODE		
STARR A	APARTMENTS A B C I		HWOOD DR RLE, NC 280			
(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 APPROPRIED TO THE	D BE	(X5) COMPLETE DATE
V 289	serves adults whos developmental disadiagnoses; (4) "D" designoses; (4) "D" designoses; (4) "E" designoses; (5) "E" designoserves adults whose substance abuse dother diagnoses; or (6) "F" designorized residence, where adult clients whose primadevelopmental disabilities, or three clients whose primadevelopmental disabilities where disabilities where disabilities where the exempt from the form the form of the condition of the exempt from the form of the exempt from the exempt from the form of the exempt from th	e primary diagnosis is a ability but may also have other nation means a facility which se primary diagnosis is ependency but may also have nation means a facility which e primary diagnosis is ependency but may also have nation means a facility in a which serves no more than whose primary diagnoses is nay also have other adult clients or three minor ary diagnoses is abilities but may also have no live with a family and the service. This facility shall be llowing rules: 10A NCAC 27G (4),(5)(A)&(B); (6); (7) H); (8); (11); (13); (15); (16); CAC 27G .0202(a),(d),(g)(1) .0203; 10A NCAC 27G .0205 27G .0207 (b),(c); 10A NCAC 10A NCAC 27G .0209[(c)(1) - edications only] (d)(2),(4); (e) ary and 10A NCAC 27G .0304 acility shall also be known as ving or assisted family living	V 289			
	This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to operate within the scope of the					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) A. BUILDING:			X3) DATE SURVEY COMPLETED	
			, 20.25			
		MHL084-064	B. WING		04/2	7/2022
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
STARR A	APARTMENTS A B C I	7	HWOOD DR RLE, NC 280			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	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 289	program affecting t (#1, #2 and #3). The Review on 4/26/22 the facility is licensed Living Facility. Review on Eacilities and Supervised living is provides residential home environment these services is the rehabilitation of indillness, a developmor a substance abustance abustance abustance abustance and Urinary Incontinual Programment on the services of Autistance of Programment of the services of the supervision when in the services of Autistance of Programment of Autistance of Programment of Autistance of Autistan	hree of three audited clients e findings are: of the facility license revealed ed as a 5600C Supervised riew of the Rules for Mental and Disabilities and Substance d Services revealed a 24-hour facility which I services to individuals in a where the primary purpose of se care, habilitation or ividuals who have a mental ental disability or disabilities, ase disorder, and who require in the residence. 22 of client #1's record 6/24/93. stic Disorder, Borderline and, Hyperlipidemia, Myopia anence. 22 of client #2's record 12/26/95. stic Disorder, Schizoaffective red Anxiety Disorder, sies-Unspecified, Thyroid ic Rhinitis.	V 289			

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Division of Health Service Regulation
STATE FORM

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY LETED
		MHL084-064	B. WING		04/2	7/2022
<u> </u>				STATE, ZIP CODE	1	
		501 HFAT	HWOOD DR			
STARR APARTMENTS A B C D			RLE, NC 280			
(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 289	Continued From pa	ge 3	V 289			
	-She thought she had been living at home for about 20 yearsStaff normally leave the facility around 8:00 pm at night. They are in the apartments without staff until the next morningShe wasn't sure how long staff had been leaving them unsupervised at night. Interview on 4/26/22 with client #2 revealed: -He lived at the home for many yearsStaff normally left the facility around 8:00 pm at night. There is no staff until the next morning after 6:00 amHe wasn't sure how long staff had been leaving them unsupervised at night. Interview on 4/26/22 with client #3 revealed: -She thought she had been living here for over 20 yearsStaff normally leave the home around 8:15 pm or 8:30 pm at night. When staff leave the facility, they are at the group home alone with no staff supervision. Staff had been doing this for years.					
	revealed: -He was employed had been at that far and been at that far the clients were upon the apartments from 3rd shift staff for the clients had be several yearsThe clients had be sleeping hours even this facilityHe felt like the clied during sleeping hour towards their indep	nsupervised without staff at n 8 pm to 8:00 am. There is this home. en living at facility together for en unsupervised during r since he had been working at this were allowed to be alone are because they were working				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		MHL084-064	B. WING		04/2	7/2022
	PROVIDER OR SUPPLIER	501 HEAT	DRESS, CITY, S HWOOD DR RLE, NC 280			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES '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 289	community on their staff supervision. Interview on 4/26/2: -She was employed years. She worked -She normally left abecause she wants -There is no 3rd shi This facility had ope been working. Interview on 4/27/2: -She was employed years. She had bee about 2 years. Sinc agency there were shift at that facilityShe thought the facilients working toward. Interviews on 4/26/2: Regulatory Officer reall of the clients had home during 3rd she was assessed thruplansWhen she started clients had unsupereshe was told the fawith the understand shift staffThe facility never hicensedShe really couldn't	own some day without any with staff #2 revealed: with the agency for about 7 2:00 pm to 8:00 PM few minutes after 8:00 pm to ensure there are no issues. ft staff working in this facility. erated that way since she had with staff #3 revealed: with the agency for over 25 n working at this facility for e she had been with the no staff working during 3rd cility had no 3rd shift due to ards their independence. and 4/27/22 with the Chief revealed: dunsupervised time at the ift. The unsupervised time a risk assessment in their with the agency in 2014 the rvised during 3rd shift. acility was licensed in 1994 ling there would be no third and 3rd shift staff since it was give an answer as to why d shift staff. When she started	V 289			

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