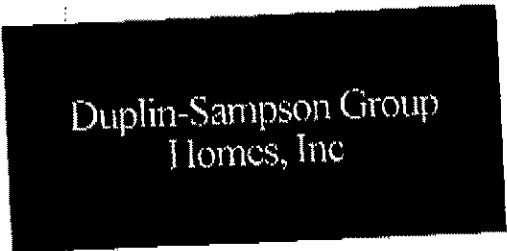


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Fax

To: Bryan From: Jamie
Fax: _____ Pages: 6
Phone: _____ Date: 5/2/22
Re: WGH (MHL-031-039)

- Urgent
- For Review
- Please Comment
- Please Reply
- Please Recycle

• Comments: _____

Date Faxed: _____
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By DHSR Mental Health Licensure & Certification at 3:22 pm, May 02, 2022

PRINTED: 04/28/2022
FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL031-039	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 04/22/2022
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NAME OF PROVIDER OR SUPPLIER WARSAW GROUP HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 716 CURTIS ROAD WARSAW, NC 28398
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(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	<p>INITIAL COMMENTS</p> <p>An annual and follow up survey was completed on April 22, 2022. Deficiencies were cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .5600C, Supervised Living for Adults with Developmental Disabilities.</p> <p>This facility is licensed for 6 and currently has a census of 4. The survey sample consisted of audits of 3 current clients.</p>	V 000	<p><i>OP will ensure all Plans are reviewed & updated in a timely fashion.</i></p>	
V 112	<p>27G .0205 (C-D) Assessment/Treatment/Habilitation Plan</p> <p>10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN</p> <p>(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.</p> <p>(d) The plan shall include:</p> <ol style="list-style-type: none"> (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	<p><i>OP will ensure admissions are done w/in 30 days.</i></p>	5/2/22

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

Jamie McNeil

Exec. Director/OP

TITLE

(X8) DATE

5/2/22

PRINTED: 04/28/2022
FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL031-039	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 04/22/2022
NAME OF PROVIDER OR SUPPLIER WARSAW GROUP HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 716 CURTIS ROAD WARSAW, NC 28398		
(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	Continued From page 1 This Rule is not met as evidenced by: Based on record reviews and interview the facility failed to assure treatment plans were at least reviewed annually, and failed to develop a treatment plan within 30 days of admission for two of three audited clients (#3, #4). The findings are: Finding #1: Review on 4/22/22 of client #3's record revealed: - 45 year-old female - Admission date of 3/1/22 - Diagnoses of schizoaffective bipolar type, intellectual disability - mild, diabetes, acne, and chronic constipation - Admission assessment completed 2/16/22 - No Treatment Plan completed since admission to the facility. Finding #2: Review on 4/22/22 of client #4's record revealed: - 43 year-old female - Admission date of 3/11/16 - Diagnoses of unspecified mood disorder, unspecified psychosis, intellectual disability - mild Review on 04/22/22 of client #4's Treatment Plan dated 3/4/21 revealed: - No annual review completed in March, 2022. Interview on 4/22/22 the Executive Director stated: - She was aware a treatment plan had to be	V 112		

Division of Health Service Regulation

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NAME OF PROVIDER OR SUPPLIER WARSAW GROUP HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 716 CURTIS ROAD WARSAW, NC 28398
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V 112	Continued From page 2 completed within 30 days of admission to the facility. - She was still gathering additional information for client #3, as the accompanying information presented during the transition phase was sparse. - She didn't realize she had just missed the date for the annual review of client #4's plan. - She would follow up on client #3 and client #4's treatment plans to ensure current goals and strategies were in place and updated.	V 112		
V 752	27G .0304(b)(4) Hot Water Temperatures 10A NCAC 27G .0304 FACILITY DESIGN AND EQUIPMENT (b) Safety: Each facility shall be designed, constructed and equipped in a manner that ensures the physical safety of clients, staff and visitors. (4) In areas of the facility where clients are exposed to hot water, the temperature of the water shall be maintained between 100-116 degrees Fahrenheit. This Rule is not met as evidenced by: Based on observation and interview, the facility water temperatures were not maintained between 100-116 degrees Fahrenheit in areas where clients were exposed to hot water. The findings are: Observation on 4/21/22 at approximately 11:00am revealed: -The hot water temperature in bathroom #1 was 126 degrees Fahrenheit at the sink. -The hot water temperature at the kitchen sink was 126 degrees Fahrenheit.	V 752	ED/RSC will get w/ maintenance to ensure water heater is adjusted ED spoke w/ staff about letting water run for 10-15 minutes before testing. ED will monitor readings.	

PRINTED: 04/28/2022
FORM APPROVED

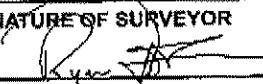
Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL031-039	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 04/22/2022
NAME OF PROVIDER OR SUPPLIER WARSAW GROUP HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 716 CURTIS ROAD WARSAW, NC 28398		
(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 752	Continued From page 3 Interview on 4/22/22 the Executive Director stated: - She would follow up to ensure the proper range of water temperature was maintained.	V 752		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER MHL031-039	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT 4/22/2022
NAME OF FACILITY WARSAW GROUP HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 716 CURTIS ROAD WARSAW, NC 28398	

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix V0108	Correction	ID Prefix V0118	Correction	ID Prefix V0536	Correction
Reg. # 27G .0202 (F-I)	Completed	Reg. # 27G .0209 (C)	Completed	Reg. # 27E .0107	Completed
LSC	04/22/2022	LSC	04/22/2022	LSC	04/22/2022
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
REVIEWED BY STATE AGENCY <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR 		DATE 4/22/22
REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE		DATE
FOLLOWUP TO SURVEY COMPLETED ON 10/17/2019		<input type="checkbox"/> CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2587) SENT TO THE FACILITY? <input type="checkbox"/> YES <input type="checkbox"/> NO			