TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  V 000 INITIAL COMMENTS  An annual and follow up survey was completed on 5/20/22. Deficiencies were cited.  This facility is licensed for the following service category: 10A NCAC 27G .5600A Supervised Living for Adults with Mental Illness  This facility is licensed for 6 clients and currently has a census of 6. The survey sample consisted of audits of 3 current clients.  V 112  27G .0205 (C-D)  Assessment/Treatment/Habilitation Plan  10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN  (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.  (d) The plan shall include:  (1) client outcome(s) that are anticipated to be achieved by provision of the service and a	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED			
CAMPIECE   CAMPIECE			MHL092-899	B. WING		05/20/2		
Name	NAME OF PROVIDER OR SUPPLIER  HARRISON HOMES  2609 FER			NBROOK RO				
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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.		An annual and follo on 5/20/22. Deficier  This facility is licens category: 10A NCALiving for Adults with this facility is licens has a census of 6. of audits of 3 currer  27G .0205 (C-D)  Assessment/Treatm  10A NCAC 27G .02  TREATMENT/HABIPLAN  (c) The plan shall be assessment, and in legally responsible of admission for clie receive services be (d) The plan shall if (1) client outcome (achieved by provision projected date of action (2) strategies; (3) staff responsible person (5) basis for evaluation outcome achievement (6) written consent responsible party, oprovider stating why	w up survey was completed noies were cited.  sed for the following service C 27G .5600A Supervised h Mental Illness sed for 6 clients and currently The survey sample consisted nt clients.  nent/Habilitation Plan  Sed ASSESSMENT AND ILITATION OR SERVICE  sed edveloped based on the partnership with the client or person or both, within 30 days ents who are expected to yond 30 days.  Include:  s) that are anticipated to be on of the service and a chievement;  e;  review of the plan at least attion with the client or legally or both;  attion or assessment of the ent; and or agreement by the client or or a written statement by the					

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

(X6) DATE TITLE

				(3) DATE SURVEY COMPLETED		
		MHL092-899	B. WING		05/2	20/2022
NAME OF PROVIDER OR SUPPLIER  STREET ADI  2609 FER		DRESS, CITY, S RNBROOK RO I, NC 27610	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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
V 112	Continued From pa		V 112			
	Based on record re failed to ensure trea and implemented for #4, #6). The finding  Review on 5/19/22 - admitted 7/29/2	view and interview the facility atment plans were developed or 3 of 3 audited clients (#2, is are:  of client #2's record revealed: contizophrenia, Glaucoma, ypercholestermia				
	<ul><li>admitted 10/30/</li><li>Schizoaffective</li><li>Hyperlipidemia &amp; H</li></ul>	, Schizoaffective Disorder,				
	<ul> <li>admitted 12/1/1</li> <li>diagnoses of Some Depression, Ovaria</li> </ul>	of client #6's record revealed: 4 chizoaffective Disorder, n Syndrome & Hyperlipidemia olan dated 11/14/20				
	Professional (QP) r - the day prograr treatment plans	5/19/22 the Qualified eported: n had not sent the current h back out to the day program				
	During interview on reported:	5/19/22 the Licensee				

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		MIII 002 000	B WING		05/0	0/0000
NAME OF I		MHL092-899	l		05/2	0/2022
	PROVIDER OR SUPPLIER		NBROOK RO	STATE, ZIP CODE DAD		
HARRIS	ON HOMES		, NC 27610			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
V 112	Continued From pa	ge 2	V 112			
	complete the treatn	the QP complete the				
V 121	27G .0209 (F) Med	ication 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 formal of the following shall be	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 site manager shall assure that n is informed of the results of edical intervention is indicated. the drug regimen review shall client record along with				
	failed to ensure psy	et as evidenced by: view and interview the facility chotropic drug regimens were 3 audited clients (#2, #4 & #6).				
	<ul> <li>admitted 7/29/2</li> <li>diagnoses of S</li> <li>Hyperlipidemia &amp; H</li> <li>last drug regimen</li> </ul>	chizophrenia, Glaucoma, ypercholesterolemia en completed 7/8/21				
	Review on 5/19/22	of client #4's record revealed:				

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	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		MHL092-899	B. WING		05/2	0/2022
NAME OF PROVIDER OR SUPPLIER  STREET ADD  2609 FERN		DRESS, CITY, S NBROOK RO , NC 27610	STATE, ZIP CODE DAD			
(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 121	Hyperlipidemia & H - last drug regime Review on 5/19/22 - admitted 12/1/1 - diagnoses of Score Depression, Ovaria - last drug regime During interview on reported: - he and the Quaresponsible for ension completed every 6 - will follow up with 27G .0303(c) Facility 10A NCAC 27G .03 EXTERIOR REQUI	/14 /, Schizoaffective Disorder, ypertension en completed 7/8/21  of client #6's record revealed: 4 chizoaffective Disorder, n Syndrome & Hyperlipidemia en completed 7/8/21  5/20/22 the Licensee  diffied Professional were uring drug regimens were months th the pharmacy  ty and Grounds Maintenance  103 LOCATION AND REMENTS	V 121			
	maintained in a safe manner and shall bodor.  This Rule is not me Based on observatifailed to ensure the maintained in a safe manner. The finding	on and interview the facility facility grounds were e, clean and attractive				

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		MHL092-899	B. WING		05/	20/2022
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
HARRIS	ON HOMES		RNBROOK RO H, NC 27610	DAD		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
V 736	Continued From pa	ge 4	V 736			
	- the grass w facility	as knee high around the				
		5/19/22 staff #1 reported: as supposed to cut the grass				
	During interview on 5/20/22 the Licensee reported: - the grass had not been cut in 2 weeks - the gentlemen that usually cut the facility's grass did not show - he will follow up with him					
	This deficiency cons and must be correc	stitutes a re-cited deficiency ted within 30 days.				

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