STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL092-248	A. BUILDING: _____ B. WING _____	06/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVANS-WALSTON HOME	808 HAWKS VIEW COURT FUQUAY VARINA, NC 27526

(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	INITIAL COMMENTS An Annual Survey was completed 6/28/22. A deficiency was cited. This facility is licensed for the following service category: 10A NCAC 27G 5600F Supervised Living/Alternative Family Living This facility is licensed for three clients and currently has a cencus of three. The survey sample consisted of audits of three current clients.	V 000	To correct the deficient area, a comprehensive admission assessment will be maintained and kept in the client's file along with the client record. The admission assessment will detail the client's admission and discharge date, identifying information, signed statement from legally responsible party granting permission to seek emergency care from an hospital or physician, services provided, medications, among other pertinent information and be kept on file for each new and future clients. The individual client's file will be audited internally by the licensee at the time of a new client admission and yearly at the time of their ISP meeting to ensure that each file has the appropriate documentation and prevent future deficiencies.	
V 113	27G .0206 Client Records 10A NCAC 27G .0206 CLIENT RECORDS (a) A client record shall be maintained for each individual admitted to the facility, which shall contain, but need not be limited to: (1) an identification face sheet which includes: (A) name (last, first, middle, maiden); (B) client record number; (C) date of birth; (D) race, gender and marital status; (E) admission date; (F) discharge date; (2) documentation of mental illness, developmental disabilities or substance abuse diagnosis coded according to DSM IV; (3) documentation of the screening and assessment; (4) treatment/habilitation or service plan; (5) emergency information for each client which shall include the name, address and telephone number of the person to be contacted in case of sudden illness or accident and the name, address and telephone number of the client's preferred physician; (6) a signed statement from the client or legally responsible person granting permission to seek	V 113		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Glenda Evans-Walston | TITLE: Owner/Operator | (X6) DATE: 7-27-2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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V 113	Continued From page 1 emergency care from a hospital or physician; (7) documentation of services provided; (8) documentation of progress toward outcomes; (9) if applicable: (A) documentation of physical disorders diagnosis according to International Classification of Diseases (ICD-9-CM); (B) medication orders; (C) orders and copies of lab tests; and (D) documentation of medication and administration errors and adverse drug reactions. (b) Each facility shall ensure that information relative to AIDS or related conditions is disclosed only in accordance with the communicable disease laws as specified in G.S. 130A-143. This Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure a full client record was maintained to reflect diagnoses, documentation of screening assessment and services provided for one of three audited clients (#1). The findings are: Review on 6/28/22 of client #1's record revealed: -Admission date per licensee -3/1/22 -Diagnoses on Treatment Plan- Severe Intellectually Developmental Disability, Cerebral Palsy and Seizure Disorder. -No face sheet present with identifying information such as admission date, diagnoses, strengths/weakness and services needed. -No information present that was gathered at admission to assess the clients needs.	V 113		

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V 113	Continued From page 2 During interview the Licensee stated: -Client #1 came to her temporary in March and leaving in August 2022. -Usually completed a face sheet with all the information, but did not have one for client #1. -Gathered information prior to admission such as talking with guardian and care coordinators, but had not documented this. -Never completed an admission assessment. -All their strengths and needs are in the treatment plans. -Client #1 also had a behavior plan they follow regarding her mitts and dealing with her open wounds. -Will make a form more comprehensive to address the clients information upon admission.	V 113		