STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND FLAN OF CONNECTION			A. BUILDING:			
MHL064-095		B. WING		R <b>04/14/2022</b>		
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
STEVE A	STEVE AVENT 3925 SUNSET AVENUE ROCKY MOUNT, NC 27803					
(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 SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
V 000	INITIAL COMMENT	TS .	V 000			
		ow Up Survey was completed deficiency was cited.				
	This facility is licens 10A NCAC 27G .56 Living/Alternate Far					
		sed for 3 and currently has a urvey sample consisted of clients.				
V 290	27G .5602 Supervis	sed Living - Staff	V 290			
	numbers specified of this Rule shall be enable staff to resp needs.  (b) A minimum of compresent at all times premises, except whabilitation plan doccapable of remaining without supervision as needed but not I the client continues the home or common specified periods of (c) Staff shall be pure following client-staff child or adolescent (1) children or continues the home or common specified periods of (c) Staff shall be pure following client-staff child or adolescent (1) children or continues the home or common specified periods of (c) Staff shall be pure following client-staff child or adolescent (1) children or continues the continues th	in Paragraphs (b), (c) and (d) a determined by the facility to ond to individualized client one staff member shall be when any adult client is on the then the client's treatment or cuments that the client is in the home or community. The plan shall be reviewed ess than annually to ensure to be capable of remaining in unity without supervision for time. The plan shall be reviewed essent in a facility in the fratios when more than one client is present: or adolescents with substance				
	of one staff present clients present. Ho present during slee	all be served with a minimum for every five or fewer minor owever, only one staff need be ping hours if specified by the o procedures determined by ; or				

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BOILDING.		R	
		MHL064-095	B. WING		04/14/2022	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
STEVE A	WENT		SET AVENU OUNT, NC			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	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 290	developmental disa one staff present for present and two star more clients preser need be present duspecified by the endetermined by the endetermi	or adolescents with abilities shall be served with or every one to three clients aff present for every four or nt. However, only one staff uring sleeping hours if altergency back-up procedures governing body. The serve clients whose primary nee staff member who is on d in alcohol and other drug ms and symptoms of ations to alcohol and other drug less of a certified substance nall be available on an	V 290			
	interview the facility clients' (#1, #3) treat capability of being it and facility without periods of time. The a. Review on 4/13/2 revealed:  - Admitted: 9/3/1  - Diagnoses: Chipisease, Schizoaffe Developmental Distance.	ion, record review and realized to ensure two of three atment plans documented in the home and/or community supervision for specified e findings are:  22 of client #1's record  0 ronic Obstructive Pulmonary ective and Mild Intellectual ability (IDD)  1 dated 1/28/22 with no insupervised time either in the				

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DIVISION	of Health Service Re	eguiation	r		T		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
		IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED		
					_		
MHI 064 005		MHL064-095	B. WING		R <b>04/14/2022</b>		
		III112004-000			0+/1	7/2022	
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
STEVE A	VENT	3925 SUN	SET AVENU	E			
SILVE	W LIVI	ROCKY M	OUNT, NC	27803			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)	
PRÉFIX		/ MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL		COMPLETE DATE	
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROI DEFICIENCY)	PRIAIE	DAIL	
				,			
V 290	Continued From pa	ge 2	V 290				
	Observation and inf	terview on 4/13/22 between					
	9:10 AM and 10:30						
		n the bed and client #2 (who					
		nsupervised time in his record)					
	was under the carp	ort listening to radio and					
	smoking.						
		orted no one else was at the					
	group home during						
	<ul> <li>Client #1 and Division of Health Service</li> <li>Regulation staff attempted to reach Licensee.</li> <li>Client #1 reported the Licensee's phone did</li> </ul>						
	not ring and went to	voicemail.					
	During interview on 4/13/22, the Licensee reported:						
	- All clients had 2 hours of unsupervised time						
	in the home.	nome because had taken client					
	#3 to a physician's appointment The physician's appointment lasted longer						
	than he anticipated.						
	than no anticipated.						
	b. Review on 4/13/2	22 of client #3's record					
	revealed:						
	- Admitted: 2018						
	<ul> <li>Diagnoses: Aut</li> </ul>	ism, Mood Disorder and Mild					
	IDD_						
	- Treatment plan						
		ntain his independence with					
		He wants to continue working					
		ours at [restaurant]/4 or 5 days					
	per week, 6 hours p						
		rking not working:attempts to vork. [Client #3] sometimes					
		ry mat during unsupervised					
	time."	y mat during unsupervised					
		Il for safety decisions by not					
		neighborhoods or mingling					
	with strangers.						
		cumentation regarding length					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION ( A. BUILDING:		(X3) DATE COM	(X3) DATE SURVEY COMPLETED	
MHL064-095		B. WING			R <b>14/2022</b>		
	NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  3925 SUNSET AVENUE						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TON SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
V 290	of time in the home unsupervised time.  During interview on Qualified Profession - He served the Qualified Profession - He completed Quassessments to detain the inherited the plans pre-pandemic - He had not not clients #1 and #3 discussion of the group home.	and/or community for  4/13/22 and 4/14/22 the nal reported: group home since 2018. unsupervised time. unsupervised time termine their eligibility. e clients and their treatment c. ced the treatment plans for d not specify times or if the was in the community and/or stitutes a re-cited deficiency	V 290				

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