STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL026-814	A. BUILDING: _____ B. WING _____	R 08/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMERHILL	6350 HAWFIELD DRIVE FAYETTEVILLE, NC 28303

(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 and follow up survey was completed on August 3, 2022. A deficiency was cited. This facility is licensed for the following service category: 10A NCAC 27G .5600B Supervised Living for Minors with Developmental Disabilities. This facility is licensed for 4 and currently has a census of 2. The survey sample consisted of audits of 2 current clients.	V 000		
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 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		

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V 112	Continued From page 1 This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to develop and implement goals and strategies based on assessment for 2 of 2 current clients (#1, #2). The findings are: Finding #1 Review on 8/2/22 of client #1's record revealed: -12 year old male. -Admitted on 8/16/21. -Diagnoses of Autism Spectrum Disorder, Attention Deficit Hyperactive Disorder and PICA. Review on 8/2/22 of client #1's treatment plan dated 6/1/22 revealed: -There were no strategies for the client goals. Attempted interview on 8/2/22 with client #1 revealed he had limited speech. Finding #2 Review on 8/2/22 of client #2's record revealed: -16 year old male. -Admitted on 2/26/22. -Diagnoses of Autism Spectrum Disorder, Incontinence, Intellectual Disability, Severe and Unspecified Disruptive, Impulse Control, and Conduct Disorder. Review on 8/2/22 of client #2's treatment plan dated 12/29/21 revealed: -There were no goals or strategies for client #2.	V 112		

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 112	Continued From page 2 Client #2 is nonverbal and was on a home visit during survey. Interview on 8/2/22 the Director of Services/Qualified Professional stated: -The Care Coordinator completed client #1's treatment plan. -She had begun to develop client #1's short range goals and strategies. -Client #2 received a new service and she was not clear on how to document the service or goals. -She completed the treatment plan for client #2. -She understood the client treatment plans should include goals and strategies based on the client needs.	V 112		