		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
	OF CORRECTION	IDENTIFICATION NOMBER.	A. BUILDING:			
		MHL016-009	B. WING			R 30/2022
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE		
SCHOON	IER SHORES	681 HIGH				
			RT, NC 28516			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 000	INITIAL COMMENT	ſS	V 000			
	on August 30, 2022	low up survey was completed . The complaint was .e #NC00191221). Deficencies				
	category: 10A NCA	sed for the following service C 27G .5600C Supervised h Developmental Disabilities.				
		ed for 6 and currently has a urvey sample consisted of 3 1 former client.				
V 290	27G .5602 Supervis	sed Living - Staff	V 290			
	numbers specified i of this Rule shall be	502 STAFF os above the minimum in Paragraphs (b), (c) and (d) e determined by the facility to ond to individualized client				
	present at all times premises, except w habilitation plan doo capable of remainin	one staff member shall be when any adult client is on the hen the client's treatment or cuments that the client is ng in the home or community . The plan shall be reviewed				
	as needed but not I the client continues the home or common specified periods of (c) Staff shall be pr	ess than annually to ensure to be capable of remaining in unity without supervision for time. resent in a facility in the				
	child or adolescent (1) children o abuse disorders sh	f ratios when more than one client is present: r adolescents with substance all be served with a minimum for every five or fewer minor				
	clients present. Ho	ping hours if specified by the				

of Health Service Re	egulation				1 APPROVED
T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		E SURVEY PLETED
	MHL016-009	B. WING			R 30/2022
ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
	681 HIG	HWAY 101			
IER SHORES	BEAUFO	ORT, NC 28516			
(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO T	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
Continued From pa	ge 1	V 290			
the governing body (2) children of developmental disa one staff present fo present and two sta more clients present need be present du specified by the em determined by the g (d) In facilities whice diagnosis is substat (1) at least or duty shall be trained withdrawal symptom secondary complicat drug addiction; and (2) the servic abuse counselor sh	; or r adolescents with ibilities shall be served with or every one to three clients aff present for every four or nt. However, only one staff iring sleeping hours if is ergency back-up procedures governing body. ch serve clients whose primary nce abuse dependency: ne staff member who is on d in alcohol and other drug ns and symptoms of ations to alcohol and other d ations to alcohol and other d ations to alcohol and other d ations to alcohol and other d ations to alcohol and other d	,			
Based on record re facility failed to ensu- habilitation plan doo capable of remainin without supervision affecting three of th #4). The findings ar Finding #1: Review on 08/25/22 revealed: - 46 year old male. - Admission date 12 - Diagnoses of Mod	views and interviews, the ure a clients' treatment or cumented the client was ng in the home or community for specified periods of time ree audited clients (#2, #3 and re: 2 of client #2's record 2/03/10.	E			
	T OF DEFICIENCIES OF CORRECTION PROVIDER OR SUPPLIER ER SHORES SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From par emergency back-up the governing body (2) children of developmental disa one staff present for present and two sta more clients preser need be present du specified by the em determined by the g (d) In facilities whice diagnosis is substa (1) at least or duty shall be trained withdrawal symptor secondary complica drug addiction; and (2) the service abuse counselor sh as-needed basis fo This Rule is not me Based on record re facility failed to ens habilitation plan doo capable of remainin without supervision affecting three of th #4). The findings at Finding #1: Review on 08/25/22 revealed: - 46 year old male. - Admission date 12 - Diagnoses of Moo	OF CORRECTION IDENTIFICATION NUMBER: MHL016-009 PROVIDER OR SUPPLIER STREET A ER SHORES 681 HIGI BEAUFC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 1 emergency back-up procedures determined by the governing body; or (2) children or adolescents with developmental disabilities shall be served with one staff present for every one to three clients present and two staff present for every four or more clients present. However, only one staff need be present during sleeping hours if specified by the emergency back-up procedures determined by the governing body. (d) In facilities which serve clients whose primary diagnosis is substance abuse dependency: (1) at least one staff member who is on duty shall be trained in alcohol and other drug withdrawal symptoms and symptoms of secondary complications to alcohol and other drug addiction; and (2) the services of a certified substance abuse counselor shall be available on an as-needed basis for each client. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure a clients' treatment or habilitation plan documented the client was capable of remaining in the home or community without supervision for specified periods of time affecting three of three audited clients (#2, #3 and #4). The findings are: Finding #1: Review on 08/25/22 of client #2's record revealed: - 46 year old male. - Admission date 12/03/10. - Dia	TO E DEFICIENCIES OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE A. BUILDING:	TOP DEPRICIENCIES (X1) PROVIDERSUPPLIER/CLA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING: MHL016-009 B. WING INFOUNDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE ER SHORES 631 HIGHWAY 101 BEAUFORT, NC 28516 SUMMARY STATEMENT OF DEFICIENCIES (BCH) DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF ((BCH) DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX PROVIDER'S PLAN OF ((BCH) DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX PROVIDER'S PLAN OF ((BCH) DEFICIENCY DO CONTROL OR STREFERNECED TO T DEFICIENC Continued From page 1 V 290 ID PREFIX PROVIDER'S PLAN OF ((BCH) DEFICIENCY OR LSC IDENTIFYING INFORMATION) V 290 Continued From page 1 V 290 V 290 ID emergency back-up procedures determined by the governing body; or (2) children or adolescents with developmental disabilities shall be served with one staff present for every four or more clients present. However, only one staff need be present during sleeping hours if specified by the emergency back-up procedures determined by the governing body; (2) In facilities which serve clients whose primary diagnosis is substance abuse dependency: (1) at least one staff member who is on duty shall be trained in alcohol and other drug addiction; and (2) The services of a certified substance abuse counselor shall be available on an as-needed basis for each client Was capable of memainign in the home or community wit	TO F DEFICIENCIES (Y1) PROVIDERSUPPLIERICLA DENTFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A BUILDING: (X3) DATA ROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE (BX) ER SHORES 681 HIGHWAY 101 BEAUFORT, NC 28516 SUMMARY STATEMENT OF DEFICIENCES (EACH DEFICIENCY MUST BE PRECEDED BY FULL RECULTIONY OR LSC DENTFYMO INFORMATION) ID PROVIDER'S PLAN OF CORRECTION (EACH OFFICIENCY MUST BE PRECEDED BY FULL RECULTIONY OR LSC DENTFYMO INFORMATION) ID PROVIDER'S PLAN OF CORRECTION (EACH OFFICIENCY MUST BE PRECEDED BY FULL RECULTIONY OR LSC DENTFYMO INFORMATION) ID PROVIDER'S PLAN OF CORRECTION (EACH OFFICIENCY MUST BE PRECEDED BY FULL RECULTIONY OR LSC DENTFYMO INFORMATION) ID PROVIDER'S PLAN OF CORRECTION (EACH OFFICIENCY MUST BE PRECEDED BY FULL RECULTIONY OR LSC DENTFYMO INFORMATION) ID PROVIDER'S PLAN OF CORRECTION (EACH OFFICIENCY MUST BE PRECEDED BY FULL RECULTIONY OR LSC DENTFYMO INFORMATION) ID PROVIDER'S PLAN OF CORRECTION (EACH OFFICIENCY MUST BE PRECEDED BY FULL RECULTIONY OR LSC DENTFYMO INFORMATION) ID RECULTION (EACH OFFICIENCY MUST BE PRECEDED BY FULL RECULTIONY OR LSC DENTFYMO INFORMATION) ID RECULTION (CONSERVENT OR LSC DENTFYMO INFORMATION) ID RECULTION (EACH OFFICIENCY MUST BE PRECEDED BY FULL RECULTION (CONTINE OBACH DEVENT OR DESTINGTION (CONTINUES TO EACH DEVENT OR DEVE

Division of Health S STATE FORM

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		BERNI IO, HOITHOUBER.	A. BUILDING:		R	
		MHL016-009	B. WING			30/2022
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
SCHOON	IER SHORES		HWAY 101 DRT, NC 28516	5		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
V 290	Continued From pa	age 2	V 290			
	Anxiety Disorder.					
	assessment for "U 11/18/21 revealed:	owed 2 hours of unsupervised				
	revealed: - No documentatio	Profile (PCP) dated 07/01/22 n of client #2's ability to remair nmunity without supervision for				
	 His sister was his He knew where t located. He had his sister to call 911. 	/22 client #2 stated: s guardian. he phone in the facility was 's phone number and was able tay at the facility unsupervised				
	revealed: - 56 year old male. - Admission date o	of 08/03/07. derate IDD and Major				
	assessment for "U 05/15/22 revealed:	owed 2 hours of unsupervised				
	Review on 08/25/2 10/01/21 revealed	2 of client #3's PCP dated				

			(X2) MULTIPLE CONSTRUCTION			E SURVEY PLETED
			A. BUILDING:			R
		MHL016-009	B. WING			30/2022
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	ATE, ZIP CODE		
SCHOON	NER SHORES		HWAY 101 RT, NC 28516			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OI (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLET DATE
V 290	Continued From pa	ige 3	V 290			
	 No documentation of client #3's ability to remain in the home or community without supervision for specified periods of time. Interview on 08/25/22 client #3 stated: He was his own guardian. He was able to have unsupervised time at the facility. 					
	revealed: - 62 year old male. - Admission date of - Moderate IDD, Ca	2 of client #4's record f 08/20/09. ardiac Pacemaker, Chronic d Unspecified Glaucoma.				
	assessment for "Ur 11/18/21 revealed:	2 of client #4's facility nsupervised Time" dated wed 2 hours of unsupervised nd community.				
	01/26/22 revealed: - No documentation	2 of client #4's PCP dated n of client #4's ability to remain munity without supervision for f time.				
		22 staff #1 stated all the / had unsupervised time.				
	stated:	22 the Qualified Professional en assessed for unsupervised				
	- She understood th have documentatio remain in the home	ne treatment plans needed to n on the client's ability to or community without cified periods of time.				

	of Health Service Re	egulation				
	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		MHL016-009	B. WING			R 30/2022
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	TATE, ZIP CODE		
SCHOO	NER SHORES		IWAY 101			
			RT, NC 28516			
(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 DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
V 291	10A NCAC 27G .56 (a) Capacity. A factor six clients when the developmental disa on June 15, 2001, a than six clients at the provide services at licensed capacity. (b) Service Coordin maintained between qualified profession treatment/habilitation (c) Participation of Responsible Person provided the opport relationship with he means as visits to t the facility. Reports annually to the pare legally responsible Reports may be in the conference and shap progress toward me (d) Program Activiti activity opportunities needs and the treat Activities shall be d inclusion. Choices or legal system is in safety issues becom	cility shall serve no more than a clients have mental illness or abilities. Any facility licensed and providing services to more nat time, may continue to no more than the facility's nation. Coordination shall be n the facility operator and the als who are responsible for on or case management. the Family or Legally n. Each client shall be tunity to maintain an ongoing r or his family through such he facility and visits outside a shall be submitted at least ent of a minor resident, or the person of an adult resident. writing or take the form of a all focus on the client's eeting individual goals. ies. Each client shall have s based on her/his choices, tment/habilitation plan. esigned to foster community may be limited when the court hvolved or when health or ne a primary concern.		DEFICIENC	27)	

STATEMEN	of Health Service Re IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	. ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
and plan	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		
		MHL016-009	B. WING		R 08/30/2022
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, ST	TATE, ZIP CODE	
SCHOON	IER SHORES	681 HIGH BEAUFOR	NAY 101 RT, NC 28516	i	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE COMPLET THE APPROPRIATE DATE
V 291	Continued From pa	ige 5	V 291		
	one of three former clients (FC) (#6). The findings are:				
	record revealed: - 22 year old male. - Admission date of - Diagnoses of Frag Deficit Disorder, Att Disorder, Developm Disorder. - Date of discharge Review on 08/25/22 appointment dated - "Reason for Visit: movements Results physician instructio response etc) No tardive dyskinesia r psychiatrist who is recommended. Me what?: Claritin (treat (Loratadine) 10 mg Review on 08/25/22 for FC #6's and dat - "D/C (Discontinue evening."	gile X Syndrome, Attention tention Deficit Hyperactivity nental Delay and Sleep 07/31/22. 2 of FC #6's doctor 06/03/22 revealed: Concern about involuntary s of Appointment: (to include ns/comments, individual's movements consistent with noted, Appointment with prescribing Adderall dications PrescribedIf yes, ats seasonal allergies) (milligrams) each evening." 2 of a signed physician order red 06/15/22 revealed: b) Loratidine 10mg 1 each			
	Medication Adminis - Loratadine 10mg evening.	2 of FC #6's June 2022 stration Record revealed: - take one tablet every icate Loratadine was 5/22 thru 06/13/22.			
		22 FC #6's Guardian stated: informed of FC #6's doctor /03/22.			

STATE FORM

PFMT11

If continuation sheet 6 of 7

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE	(X3) DATE SURVEY COMPLETED	
	OF CORRECTION	IDENTIFICATION NOMBER.	A. BUILDING:				
		MHL016-009	B. WING			R 30/2022	
IAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE			
сноом	NER SHORES		HWAY 101 DRT, NC 28516				
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES		, PROVIDER'S PLAN OF	CORRECTION	(X5)	
PRÉFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	THE APPROPRIATE	COMPLET DATE	
V 291	Continued From pa	ige 6	V 291				
	prescribed Loratad						
	stated: - FC #6's guardian about the 06/03/22 - She was told FC t Loratadine.	22 the Qualified Professional should have been notified doctor appointment. nad not received any doses of guardians when new lered for clients.					