STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL026-983	A. BUILDING: _____ B. WING _____	R 11/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAROLINE'S DDA GROUP HOME	334 MOORE STREET EAST FAYETTEVILLE, NC 28301

(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 A follow up survey was completed on November 3, 2022. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities. This facility is licensed for 6 and currently has a census of 6. The survey sample consisted of audits of 3 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		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL026-983	A. BUILDING: _____ B. WING _____	R 11/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAROLINE'S DDA GROUP HOME	334 MOORE STREET EAST FAYETTEVILLE, NC 28301

(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 112	Continued From page 1	V 112		

This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to develop goals and strategies based on assessment and failed to complete treatment plan within 30 days of admissions for 2 or 3 clients (#4 #6). The findings are:

Finding #1
Review on 11/2/22 and 11/3/22 of client #4's record revealed:
-39 year old male.
-Admitted on 2/11/21.
-Diagnoses of Schizophrenia Paranoid type, Nicotine Dependence, Hypertension, Hypothyroidism, Depression and Anxiety.

Review on 11/2/22 and 11/3/22 of client #4's treatment plan dated 11/23/21 revealed:
-The current treatment plan used was completed with goals and strategies for previous licensee.
-The staff responsible for the treatment plan was the previous licensee.
-There were no goals or strategies based on current needs for unsupervised time or employment.

Interview on 11/3/22 client #4 stated:
-He lived at the facility for years.
-He was his own guardian.
-He had unsupervised time in the community about 30 minutes.
-He was employed 3 days a week from 1:30pm

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL026-983	A. BUILDING: _____ B. WING _____	R 11/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAROLINE'S DDA GROUP HOME	334 MOORE STREET EAST FAYETTEVILLE, NC 28301

(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 112	Continued From page 2 -8pm or if a Sunday 9am - 8pm. Finding #2 Review on 11/2/22 and 11/3/22 of client #6's record revealed: -21 year old male. -Admitted on 1/19/22. -Diagnoses of Paranoid Schizophrenia, Attention Deficit Hyperactivity Disorder and Disruptive Mood Dysregulation Disorder. Review on 11/2/22 and 11/3/22 of client #6's treatment plan dated 1/11/22 revealed: -Current treatment plan was used was completed by previous therapeutic foster home. -There was no treatment plan for the new licensee with goals or strategies. -There were no goals or strategies based on current needs for unsupervised time or employment. Interview on 11/3/22 of client #6 stated: -He lived at the facility for almost a year. -He was employed and worked on a local military base. -He worked 3 days a week from approximately 1:30pm - 8pm. Interview on 11/3/22 the Qualified Professional stated: -She was responsible for completing treatment plans for the clients who did not attend the Psychosocial Rehabilitation (PSR). -She discussed the client facility goals with the PSR. -The PSR just began working on client #4's treatment plan on 11/1/22. -She had not completed a treatment plan for client #6. -She would ensure a treatment plan was	V 112		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL026-983	A. BUILDING: _____ B. WING _____	R 11/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAROLINE'S DDA GROUP HOME	334 MOORE STREET EAST FAYETTEVILLE, NC 28301

(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 112	Continued From page 3 completed for all client to include goals and the staff responsible. Interview on 11/3/22 the Administrator stated: -She understood treatment plans should be based assessment and client needs. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 112		
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 emergency care from a hospital or physician; (7) documentation of services provided;	V 113		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL026-983	A. BUILDING: _____ B. WING _____	R 11/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAROLINE'S DDA GROUP HOME	334 MOORE STREET EAST FAYETTEVILLE, NC 28301

(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 113	Continued From page 4 (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 interviews and record reviews, the facility failed to maintain a client record to include minimum required information and current consents for 3 of 3 audited clients (#3, #4, #6). The findings are: Review on 11/2/22 of the facility license revealed the facility had a change of ownership effective 2/11/22. Finding #1 Review on 11/2/22 and 11/3/22 of client #3's record revealed: -35 year old male. -Admitted on 5/15/17. -Diagnoses of Autism, Seizure Disorder, Hypertension, Mild Intellectual Disability Disability and history of Equine Encephelitis. -No documentation of consent by client #4 to	V 113		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL026-983	A. BUILDING: _____ B. WING _____	R 11/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAROLINE'S DDA GROUP HOME	334 MOORE STREET EAST FAYETTEVILLE, NC 28301

(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 113	Continued From page 5 seek emergency care from a hospital or physician. -No documentation of an assessment. Finding #2 Review on 11/2/22 and 11/3/22 of client #4's record revealed: -39 year old male. -Admitted on 2/11/21. -Diagnoses of Schizophrenia Paranoid type, Nicotine Dependence, Hypertension, Hypothyroidism, Depression, Anxiety and Cognitive Behavioral Delay. Finding #3 Review on 11/2/22 and 11/3/22 of client #6's record revealed: -21 year old male. -Admitted on 1/19/22. -Diagnoses of Paranoid Schizophrenia, Attention Deficiet Hyperactivity Disorder and Disruptive Mood Dysregulation Disorder. -No documentation of consent by client #6's guardian to seek emergency care from a hospital or physician. -No documentation of an assessment. Interview on 11/3/22 the Administrator stated: -The facility had not completed consents as the new licensee. -Each client record only contained assessments and consents for previous Licensee. -The facility changed ownership in February 2022 and is not affiliated with previous licensee. -She would ensure assessments and consents were completed for facility. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 113		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL026-983	A. BUILDING: _____ B. WING _____	R 11/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAROLINE'S DDA GROUP HOME	334 MOORE STREET EAST FAYETTEVILLE, NC 28301

(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 118	Continued From page 6	V 118		
V 118	27G .0209 (C) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (c) Medication administration: (1) Prescription or non-prescription drugs shall only be administered to a client on the written order of a person authorized by law to prescribe drugs. (2) Medications shall be self-administered by clients only when authorized in writing by the client's physician. (3) Medications, including injections, shall be administered only by licensed persons, or by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer medications. (4) A Medication Administration Record (MAR) of all drugs administered to each client must be kept current. Medications administered shall be recorded immediately after administration. The MAR is to include the following: (A) client's name; (B) name, strength, and quantity of the drug; (C) instructions for administering the drug; (D) date and time the drug is administered; and (E) name or initials of person administering the drug. (5) Client requests for medication changes or checks shall be recorded and kept with the MAR file followed up by appointment or consultation with a physician.	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL026-983	A. BUILDING: _____ B. WING _____	R 11/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAROLINE'S DDA GROUP HOME	334 MOORE STREET EAST FAYETTEVILLE, NC 28301

(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 118	Continued From page 7 This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure medications were administered by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer medications for 1 of 2 paraprofessionals audited (Staff #5). The findings are: Review on 11/3/22 of staff #3's personnel record revealed: -Hire date: 6/29/22. -Job: Paraprofessional. -Medication Aide Testing Passed on 7/31/22. -No documentation of the credentials of the person who provided medication training prior to the test date. -No documentation of medication training provided by the facility. Interview on 11/3/22 staff #3 stated: -She had been employed since July as a Paraprofessional. -She worked the weekend shift. -She completed her medication training online. -She administered medications to the clients. -She had not been trained in medication administration by a person. Interview on 11/3/22 the Administrator stated: -Staff #3 completed the medication aide testing. -All staff were required to complete medication aide training with the state. -Staff #3 had administered medications to clients. -She understood medication administration training had to be completed by a registered nurse, pharmacist or other legally qualified person prior to a staff administering medications to clients.	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL026-983	A. BUILDING: _____ B. WING _____	R 11/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAROLINE'S DDA GROUP HOME	334 MOORE STREET EAST FAYETTEVILLE, NC 28301

(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 118	Continued From page 8 This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 118		
V 289	27G .5601 Supervised Living - Scope 10A NCAC 27G .5601 SCOPE (a) Supervised living is a 24-hour facility which provides residential services to individuals in a home environment where the primary purpose of these services is the care, habilitation or rehabilitation of individuals who have a mental illness, a developmental disability or disabilities, or a substance abuse disorder, and who require supervision when in the residence. (b) A supervised living facility shall be licensed if the facility serves either: (1) one or more minor clients; or (2) two or more adult clients. Minor and adult clients shall not reside in the same facility. (c) Each supervised living facility shall be licensed to serve a specific population as designated below: (1) "A" designation means a facility which serves adults whose primary diagnosis is mental illness but may also have other diagnoses; (2) "B" designation means a facility which serves minors whose primary diagnosis is a developmental disability but may also have other diagnoses; (3) "C" designation means a facility which serves adults whose primary diagnosis is a developmental disability but may also have other diagnoses; (4) "D" designation means a facility which serves minors whose primary diagnosis is substance abuse dependency but may also have other diagnoses; (5) "E" designation means a facility which	V 289		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL026-983	A. BUILDING: _____ B. WING _____	R 11/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAROLINE'S DDA GROUP HOME	334 MOORE STREET EAST FAYETTEVILLE, NC 28301

(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 289	Continued From page 9 serves adults whose primary diagnosis is substance abuse dependency but may also have other diagnoses; or (6) "F" designation means a facility in a private residence, which serves no more than three adult clients whose primary diagnoses is mental illness but may also have other disabilities, or three adult clients or three minor clients whose primary diagnoses is developmental disabilities but may also have other disabilities who live with a family and the family provides the service. This facility shall be exempt from the following rules: 10A NCAC 27G .0201 (a)(1),(2),(3),(4),(5)(A)&(B); (6); (7)(A),(B),(E),(F),(G),(H); (8); (11); (13); (15); (16); (18) and (b); 10A NCAC 27G .0202(a),(d),(g)(1)(i); 10A NCAC 27G .0203; 10A NCAC 27G .0205 (a),(b); 10A NCAC 27G .0207 (b),(c); 10A NCAC 27G .0208 (b),(e); 10A NCAC 27G .0209[(c)(1) - non-prescription medications only] (d)(2),(4); (e)(1)(A),(D),(E);(f);(g); and 10A NCAC 27G .0304 (b)(2),(d)(4). This facility shall also be known as alternative family living or assisted family living (AFL). This Rule is not met as evidenced by: Based on record review and interview, the facility failed to admit clients whose primary diagnosis was a developmental disability for 1 of 3 clients audited (client #4). The findings are: Review on 6/28/22 revealed the facility was licensed as a 10A NCAC 27G .5600C Supervised Living for Adults whose primary diagnosis is a developmental disability but may also have other diagnoses.	V 289		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL026-983	A. BUILDING: _____ B. WING _____	R 11/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAROLINE'S DDA GROUP HOME	334 MOORE STREET EAST FAYETTEVILLE, NC 28301

(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 289	Continued From page 10 Review on 11/2/22 and 11/3/22 of client #6's record revealed: -21 year old male. -Admitted on 1/19/22. -Diagnoses of Paranoid Schizophrenia, Attention Deficit Hyperactivity Disorder and Disruptive Mood Dysregulation Disorder. Interview on 11/3/22 client #6 stated: -He lived at the facility for almost a year. -His guardian was a local department of social services. Interview on 11/3/22 the Qualified Professional stated: -Client #6 did not have a developmental disability diagnosis. -She would contact the guardian to verify client #6 diagnosis. Interview on 11/3/22 the Administrator stated: -Client #6 did not have a developmental disability diagnosis. -The facility had another client who had a comprehensive clinical assessment completed and recently diagnoses with a developmental disability after the last survey. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 289		
V 290	27G .5602 Supervised Living - Staff 10A NCAC 27G .5602 STAFF (a) Staff-client ratios above the minimum numbers specified in Paragraphs (b), (c) and (d) of this Rule shall be determined by the facility to enable staff to respond to individualized client	V 290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL026-983	A. BUILDING: _____ B. WING _____	R 11/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAROLINE'S DDA GROUP HOME	334 MOORE STREET EAST FAYETTEVILLE, NC 28301

(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 290	Continued From page 11 needs. (b) A minimum of one staff member shall be present at all times when any adult client is on the premises, except when the client's treatment or habilitation plan documents that the client is capable of remaining in the home or community without supervision. The plan shall be reviewed as needed but not less than annually to ensure the client continues to be capable of remaining in the home or community without supervision for specified periods of time. (c) Staff shall be present in a facility in the following client-staff ratios when more than one child or adolescent client is present: (1) children or adolescents with substance abuse disorders shall be served with a minimum of one staff present for every five or fewer minor 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; 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.	V 290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL026-983	A. BUILDING: _____ B. WING _____	R 11/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAROLINE'S DDA GROUP HOME	334 MOORE STREET EAST FAYETTEVILLE, NC 28301

(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 290	Continued From page 12 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 two of three audited clients (#4, #6). The findings are: Finding #1 Review on 11/2/22 and 11/3/22 of client #4's record revealed: -39 year old male. -Admitted on 2/11/21. -Diagnoses of Schizophrenia Paranoid type, Nicotine Dependence, Hypertension, Hypothyroidism, Depression and Anxiety. -No evidence of an unsupervised time assessment. -Client #4's treatment plan dated 11/23/21 identified "unsupervised time in the community up to 4 hours, per group home policy" (previous licensee's policy)." Interview on 11/3/22 client #4 stated: -He lived at the facility for years. -He was his own guardian. -He had unsupervised time in the community about 30 minutes. -He was employed 3 days a week from 1:30pm -8pm or if a Sunday 9am - 8pm. Finding #2 Review on 11/2/22 and 11/3/22 of client #6's record revealed: -21 year old male.	V 290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL026-983	A. BUILDING: _____ B. WING _____	R 11/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAROLINE'S DDA GROUP HOME	334 MOORE STREET EAST FAYETTEVILLE, NC 28301

(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 290	Continued From page 13 -Admitted on 1/19/22. -No evidence of an unsupervised time assessment. Interview on 11/3/22 client #6 stated: -He lived at the facility for almost a year. -He was employed and worked on a local military base. -He worked 3 days a week from approximately 1:30pm - 8pm. Interview on 11/3/22 the Administrator stated: -Neither client #4 nor client #6 had any unsupervised time. -Client #4 and client #6 both worked, no staff accompanied them to work. -Client #4 and client #6 rode was transported to work by a private transportation service. -Client #4 and client #6 left the facility around 11am and returned around 8pm. -She understood an unsupervised time should be completed for clients with unsupervised time and should also be reflected in the client's treatment plan.	V 290		
V 736	27G .0303(c) Facility and Grounds Maintenance 10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS (c) Each facility and its grounds shall be maintained in a safe, clean, attractive and orderly manner and shall be kept free from offensive odor. This Rule is not met as evidenced by:	V 736		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL026-983	A. BUILDING: _____ B. WING _____	R 11/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAROLINE'S DDA GROUP HOME	334 MOORE STREET EAST FAYETTEVILLE, NC 28301

(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 736	Continued From page 14 Based on observation and interview, the facility was not maintained in a safe, clean, attractive and orderly manner. The findings are: Observation on 11/2/22 between 11:10 am and 11:30am during tour of the facility revealed: -In the dining area, the window air conditioner (A/C) unit had exposed coils, the front cover of the air conditioner unit was leaned against the wall. There were brownish stains around the floor heater. There was a microwave on the floor near the entrance. -In the kitchen area, there was a missing cabinet door on the food storage pantry cabinet. -In the back bathroom near the kitchen, there was a square discolored grayish patch above the shower. -In the living room area, there was a TV not in use on the floor against the TV entertainment set. The front window behind the couch had cracked glass. In the corner there was a white paint patch down the wall. -In the hallway, the flooring was cracked about 2 feet by 2 inches and appeared to be unleveled. There was a white paint patch near the bedroom door. -In the hallway bathroom, the floor heater had brownish stains and the corner exposed wires. The paint on the ceiling was not flushed against the ceiling and had a bubble like appearance. -At the entrance of client #1's bedroom, the gold metal floor strip was bent and lifted. In the bedroom, there was several rectangle floor pieces missing. -In client #2's bedroom, 2 of 3 of the light bulbs in the ceiling fan/light fixture were blown. -In client #3's bedroom, the glass window was cracked. -In client #4's bedroom, the paint was peeling and not flushed to the wall surface under the window.	V 736		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL026-983	A. BUILDING: _____ B. WING _____	R 11/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAROLINE'S DDA GROUP HOME	334 MOORE STREET EAST FAYETTEVILLE, NC 28301

(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 736	Continued From page 15 There was a brown stain on the wall under his window A/c unit. -In client #5 and client #5's bedroom, the glass was cracked in the front window. Interview on 11/2/22 the Administrator stated: -She was unsure why the cover of the A/C unit was off. -The microwave on the floor and the TV belonged to the previous Licensee. -She would have many of the areas corrected in the next couple days. -She would ensure the facility is maintained in a safe, clean, attractive and orderly manner.	V 736		