Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
ANDILAN	A. BUILDING:					
	MHL068-131 B. WING		C 11/30/2022			
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
APOGEE	HOME TWO		IGHWAY 49			
		MEBANE,	NC 27302			
(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 CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	ECTIVE ACTION SHOULD BE COMPLETE DATE	
V 000	INITIAL COMMENTS		V 000			
	A complaint survey was completed on November 30, 2022. The complaint (intake #NC00194897) was substantiated. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G. 5600A Supervised Living for Adults with Mental Illness					
	The facility is licensed census of 6. The survey sample cocurrent clients.	for 6 and currently has a onsisted of audits of 3				
V 542	27F .0105(a-c) Client Funds	Rights - Client's Personal	V 542			
	, ,					

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

(X6) DATE TITLE

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER.		A. BUILDING: _		COMI LETED		
	MHL068-131 B. WING			C 11/30/2022		
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
APOGEE	HOME TWO		IIGHWAY 49 NC 27302			
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE	
V 542	be kept separate from facility; (6) provide for personal fund account habilitation services was or legally responsible to admission of the classical for persons depositing of	a client's personal funds will an any operating funds of the the deduction from a strategy part of the payment for treatment or when authorized by the client person upon or subsequent ient; the issuance of receipts to r withdrawing funds; and client with a quarterly	V 542			
	This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to provide quarterly accounting of personal funds account for one of three audited clients (#1). The findings are: Review on 11/23/22 of Client #1's record revealed: -Admission date of 9/28/17Diagnoses of Schizoaffective Disorder, Autism Spectrum Disorder, Kline Felters Syndrome,					
	Developmental Disable - There was evidence and monthly funds leder - There was no evidence report of his personal Interview on 11/23/22 - He wanted to keep he - Confirmed that he sideposited into his facture - His funds were kept	of remaining funds, recepits dger. nce of quarterly accounting funds. with Client #1 revealed: nis funds at the facility. gned when he withdrew and				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DA A. BUILDING: CO		
MHL068-131		B. WING		C 11/30/2022		
			DRESS, CITY, STA	TE ZIP CODE	11/30/2022	
			HIGHWAY 49	, = 0052		
APOGEE	HOME TWO	MEBANE	NC 27302			
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	JLD BE COMPLETE	
V 542	Continued From page	2	V 542			
	account.					
	Interview on 11/28/22 with the Director/Qualified Professional revealed: -Client #1 had a joint bank account with his fatherClient #1 wanted to keep his money at the facilityClient #1's money was locked up in his bookClients signed on the ledger when withdrawing or depositing fundsShe provided financial reports every monthConfirmed she did not provide quaterly reports.					
V 543	27F .0105(d) Client R Funds	tights - Client's Personal	V 543			
10A NCAC 27F .0105 CLIENT'S PERSONAL FUNDS (d) Authorization by the client or legally responsible person is required before a deduction can be made from a personal fund account for any amount owed or alleged to be owed for damages done or alleged to have been done by the client: (1) to the facility; (2) an employee of the facility; (3) to a visitor of the facility; or (4) to another client of the facility.						
	This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to obtain authorization from the legally responsible person for one of three audited clients (#1) before deductions were made from the client's personal fund account. The findings are:					

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STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _					
				С			
	MHL068-131	B. WING		11/30/2022			
I	MIT 12000-101			11/30/2022			
NAME OF PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE				
APOGEE HOME TWO	7612 NC	HIGHWAY 49					
AFOGEE HOWE TWO	MEBANI	E, NC 27302					
(X4) ID SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	N (X5)			
	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD				
TAG REGULATORY OR LS	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROP DEFICIENCY)	MAIE			
V 543 Continued From page	3	V 543					
Review on 11/23/22 of	Client #1's record						
revealed:	Short #15 teacta						
-Admission date of 9/2	28/17.						
	affective Disorder, Autism						
	ine Falter's Syndrome,						
Major Depressive Disc							
Developmental Disabi	lity, Mild						
	Review on 11/23/22 of the Consumer Funds						
	Ledger dated 11/3/22 revealed:						
	including date, funds in/out,						
	amount, funds used for, amout, balance, staff						
name, consumer signa							
	cated \$800.00 was taking						
out on 11/3/22 for bed room.	bugs treatment in his						
	consumer funds ledger as						
a receipt.	consumer funds leager as						
a receipt.							
Interview on 11/23/22	with Client #1 revealed:						
-He was told he had to							
treatment.	. ,						
-He signed the ledger	for the facility to take						
\$800.00 from his acco	\$800.00 from his account in the group home.						
-He did not understand	-He did not understand why he had to pay for the						
treatment.							
	-He reported there were bed bugs in other areas						
in the house and in another client's room.							
-He kept his money loo							
-He liked living at the o	group nome.						
Interview on 11/28/22	with Client #1's Guardian						
revealed:	with Chefit #1's Guardian						
1	-She was client #1's guardian for about 4-5						
months.							
	y the facility about client #1						
having bed bugs.	, idomity debat onotic ii i						
	bugs in client #1's room for						

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the 3rd time.

-The facility made her aware they would charge

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED		
		MHL068-131			C 11/30/2022		
NAME OF PR	ROVIDER OR SUPPLIER	STREET A	ODRESS, CITY, STA	TE, ZIP CODE			
APOGEE I	HOME TWO	7612 NC	HIGHWAY 49				
AFOGLE	HOME TWO	MEBANE	, NC 27302				
(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 CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE		
V 543	POGEE HOME TWO Total Control		TAG V 543		RIATE DATE		
	guardian informed client #1's father.						

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-Clients would change into clean clothes or scrubs in the house from the back door. -Clients go to the bank once a month and had

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		
		MHL068-131	B. WING		11	C / 30/2022	
NAME OF P	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE						
APOGEE	HOME TWO		C HIGHWAY 49 E, NC 27302				
(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 CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE	
V 543	accountsClient #1 wanted his account within the factor -Some clients carried -She encouraged cliebankClient #1 wanted the account in the facility -Clients funds at the folient #1 had a lot of the yearsShe felt the guardian	money to remain in the cility. I high accounts. Into to put money in the session of the bank. If acility were locked up. If money accumulated over a gave consent. I have said it was not okay	V 543				

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