Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND FLAN	OF CORRECTION	IDENTIFICATION NOWIBER.	A. BUILDING:		OOWII LETED	
			B. WING		С	
		MHL068-131	D. WING		12/08/2022	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
APOGEE	HOME TWO		IIGHWAY 49 NC 27302			
	CLIMMADY CT	·			N	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE	
V 000	INITIAL COMMENTS		V 000			
	A complaint survey was completed on December 8, 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 for 6 and currently has a census of 6. The survey sample consisted of audits of 3 current clients.					
V 542	27F .0105(a-c) Client Funds	Rights - Client's Personal	V 542			
	10A NCAC 27F .0105 FUNDS (a) This Rule applies typically provides resiclients for more than above the age of 16 sencouraged to maintapersonal fund account This shall include, but investment of funds in (c) If funds are manaemployee, managemin accordance with position of the position o	to any 24-hour facility which dential services to individual 30 days. adult client and each minor shall be assisted and ain or invest his money in a tother than at the facility. It need not be limited to, in interest-bearing accounts. ged for a client by a facility ent of the funds shall occur olicy and procedures that: e client the right to deposit account; the receipt and distribution of account; the receipt of deposits made of others; the keeping of adequate account of the keeping of the				

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

TITLE (X6) DATE

Division of Health Service Regulation

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			
MHL068-131		B. WING	C 12/08/2022			
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
		7612 NC HI	GHWAY 49			
APOGEE	HOME TWO	MEBANE, I	NC 27302			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
V 542	(5) assure that be kept separate from facility; (6) provide for t personal fund accoun habilitation services wor legally responsible to admission of the cli (7) provide for t persons depositing or	a client's personal funds will any operating funds of the he deduction from a t payment for treatment or when authorized by the client person upon or subsequent tent; he issuance of receipts to withdrawing funds; and client with a quarterly	V 542			
	facility failed to provid personal funds accour clients (#1). The finding Review on 11/23/22 or revealed: -Admission date of 9/2-Diagnoses of Schizo Spectrum Disorder, K Major Depressive Dis Developmental Disabto-There was evidence and monthly funds leder There was no evident report of his personal Interview on 11/23/22	ews and interviews, the e quarterly accounting of int for one of three audited ings are: If Client #1's record 28/17. affective Disorder, Autism line Felters Syndrome, order and Intellectual ility, Mild. of remaining funds, recepits idger. ice of quarterly accounting funds. with Client #1 revealed:				
	-He wanted to keep his funds at the facilityConfirmed that he signed when he withdrew and deposited into his facility funds accountHis funds were kept in his book at the facilityReported he received monthly reports of his					

Division of Health Service Regulation

STATE FORM BL4N11 If continuation sheet 2 of 6

Division of Health Service Regulation

. ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		
						С
		MHL068-131	B. WING		12	2/08/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	E, ZIP CODE		
APOGEE	HOME TWO		HIGHWAY 49 E, NC 27302			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
V 542	Professional revealed -Client #1 had a joint fatherClient #1 also had m -Client #1's money w -Clients signed on the depositing fundsShe provided finance	2 with the Director/Qualified d: bank account with his	V 542			
V 543	Funds 10A NCAC 27F .0108 FUNDS (d) Authorization by responsible person is can be made from a pany amount owed or damages done or alled the client: (1) to the facility (2) an employed (3) to a visitor of (4) to another of (5)	the client or legally a required before a deduction personal fund account for alleged to be owed for eged to have been done by a set of the facility; or client of the facility.	V 543			
	facility failed to obtain legally responsible pe audited clients (#1) b	ews and interviews, the nauthorization from the erson for one of three efore deductions were made onal fund account. The				

Division of Health Service Regulation

STATE FORM BL4N11 If continuation sheet 3 of 6

Division of	<u>of Health Service Regu</u>	lation				
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		IDENTIFICATION NUMBER:	A. BUILDING:			
		B. WING		C		
		MHL068-131	B. WING		12/08/2022	
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
		7612 NC	HIGHWAY 49			
APOGEE	HOME TWO		E, NC 27302			
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR		DATE
				DEFICIENCY)		
1/540	0 " 15		1/540			
V 543	Continued From page	e 3	V 543			
	revealed:					
	-Admission date of 9/	28/17.				
		affective Disorder, Autism				
	•	(line Falter's Syndrome,				
	Major Depressive Dis					
	Developmental Disab					
	Developmental Disab	mity, wind				
	Review on 11/23/22 c	of the Consumer Funds				
		_				
	Ledger dated 11/3/22 revealed:					
		-Ledger with columns including date, funds in/out,				
	amount, funds used for, amout, balance, staff					
	name, consumer signature."					
	-Client #1's ledger indicated \$800.00 was taking out on 11/3/22 for bed bugs treatment in his					
		a bugs treatment in his				
	room.					
	_	e consumer funds ledger as				
	a receipt.					
	Intonvious on 11/22/22	with Client #1 revealed:				
		o pay for the bed bugs				
	treatment.	. for the footburte take				
	_	for the facility to take				
	\$800.00 from his account in the group home.					
	-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 a					
	-He kept his money lo	•				
	-He liked living at the	group home.				
		with Client #1's Guardian				
		revealed:				
	-She was client #1's guardian for about 4-5					
	months.					
		by the facility about client #1				
	having bed bugs.					
	-The facility found bed	d bugs in client #1's room for				
the 3rd time.						

Division of Health Service Regulation

client #1.

-The facility made her aware they would charge

STATE FORM 6899 BL4N11 If continuation sheet 4 of 6

PRINTED: 12/12/2022

Division	of Health Service Regu	ılation				M APPROVED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` '	CONSTRUCTION	(X3) DATE S COMPL	
		MHL068-131	B. WING		I	C 08/2022
NAME OF P	PROVIDER OR SUPPLIER	STREET /	ADDRESS, CITY, STAT	FE, ZIP CODE		
			C HIGHWAY 49			
APOGEE	HOME TWO	MEBAN	E, NC 27302			
(X4) ID PREFIX TAG	(EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		SHOULD BE	(X5) COMPLETE DATE	
V 543	Continued From page	e 4	V 543			
	-She was informed the client #1 was the one -She informed her su Director/Qualified Proto take funds from clie-Her supervisor told her port she was return -She was not going to -She did not give con -She was informed by going to take money accountShe said as the guar client #1's money siture. The facility was the purchase on 11/28/22 Director/Qualified Proceeding -Client #1 managed her bome.	ofessional (D/QP)was going lient #1. her stay out of it. r the day of the survey to ming the money on 11/23/22. o be involved with money. nsent. y the facility that they were from client #1's house rdian she did not deal with uations. payee.				

-Client #1 wanted his money to remain in the

had no problems with the charges.

guardian informed client #1's father. -She returned the funds on 11/23/22. -Clients go to the bank once a month.

bed bugs treatment.

upon returned from visits.

account within the facility.

money in the amount of \$800.00 on 11/3/22 for

-This had been an ongoing issue when client #1

-The exterminator provided treatment on 11/3/22. -She informed the guardian, and the guardian

-She said the guardian was fine with it and the

-Some clients carried high accounts.

-She encouraged clients to put money in the bank.

-Client #1 wanted the \$800.00 refunded to his

Division of Health Service Regulation

STATE FORM 6899 BL4N11 If continuation sheet 5 of 6

Division of Health Service Regulation

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		
		MHL068-131	B. WING		12	C / 08/2022		
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE								
APOGEE HOME	ΓWO		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 O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE		
accou -Clier -Clier the ye -She -The	nt #1 had a lot of ears. felt the guardiar	not the bank. facility were locked up. f money accumulated over gave consent. have said it was not okay	V 543					

Division of Health Service Regulation

STATE FORM BL4N11 If continuation sheet 6 of 6