Division	of	Lloalth	Comilan	Do nulle Parts
DIVISION	01	nealth	Service	Regulation

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DIVIDIO	IT OF FIGURE OCTATOS IN	equiation				
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G:	(X3) DATE SURVEY COMPLETED	
MHL001-187		B. WING		R 11/16/2022		
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY	, STATE, ZIP CODE		
CEESO	NS OF CHANGE	1536 MO	RNINGSIDE	DRIVE		
		and the second se	GTON, NC 2	27217		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU) CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE	
V 00	INITIAL COMMENT	S	V 000			
	on November 16, 20 The facility is license category: 10A NCA0 Living for Adults with The facility is license	ed for six beds and currently The survey sample		DHSR - Mental He DEC 19 2022 Lic. & Cert. Sectio		
V 107	10A NCAC 27G .020 REQUIREMENTS (a) All facilities shall description for the di which: (1) specifies the competency, work et qualifications for the (2) specifies the the position; (3) is signed by supervisor; and (4) is retained in (b) All facilities shall each staff member o provides care or serve the facility: (1) is at least 18 (2) is able to real follow directions; (3) meets the mill competency, work ex qualifications for the (4) has no substi	have a written job rector and each staff position e minimum level of education, xperience and other position; duties and responsibilities of the staff member and the the staff member's file. ensure that the director, r any other person who rices to clients on behalf of years of age; d, write, understand and inimum level of education, sperience, skills and other		This deficiency corrected with all For personnel re this staff/larapro Director requeste received document was missing and included in staff's File. Director will to assured all requ documentation is pr before himing proce Completed,	employee be responsible lived ovided	
		ATIVE'S SIGN	ATURE	/ JITLE	(X6) DATE	
		68	99 4	Surector 13	109/2022 If continuation sheet 1 of 5	

If continuation sheet 1 of 5

Division of Health Service Regulation

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED	
		MHL001-187	B. WING			R 11/16/2022	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	STATE, ZIP CODE	1 11/	10/2022	
CEESON	NS OF CHANGE		RNINGSIDE				
			GTON, NC 27	217			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	DBE	(X5) COMPLETE DATE	
V 107	Continued From pa	ge 1	V 107				
	applicants for emplo conviction. The imp decision regarding e upon the offense in which the applicant (d) Staff of a facility currently licensed, re accordance with app services provided. (e) A file shall be ma employed indicating	r or a service shall be egistered or certified in plicable state laws for the aintained for each individual the training, experience and or the position, including					
	This Rule is not met	as evidenced by:					
	27G .0205 (C-D) Assessment/Treatme	ent/Habilitation Plan	V 112				
	PLAN (c) The plan shall be assessment, and in p legally responsible pe	ITATION OR SERVICE developed based on the partnership with the client or erson or both, within 30 days its who are expected to and 30 days.					

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Division of Health Service Regulation

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	PLE CONSTRUCTION G:		E SURVEY
		MHL001-187	B. WING			R 16/2022
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY	, STATE, ZIP CODE		
CEESO	NS OF CHANGE	1536 MO	RNINGSIDE	DRIVE		
		BURLING	GTON, NC	27217		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPP DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
V 112	<ul> <li>achieved by provision projected date of action</li> <li>(2) strategies;</li> <li>(3) staff responsible</li> <li>(4) a schedule for rannually in consultaresponsible person</li> <li>(5) basis for evaluaresponsible person</li> <li>(6) written consent</li> <li>(7) responsible party, or</li> </ul>	s) that are anticipated to be on of the service and a hievement; e; eview of the plan at least tion with the client or legally or both; tion or assessment of	V 112 V <i>[]</i> 12	This citation has addressed and corrected, Actual was completed o 11-05-22. It has b signed by client a Guardian, The	PCP n een	11/23/.
	failed to ensure one of #2) treatment plan with findings are: Review on 11/15/22 of -Admission date of 9/ -Diagnoses of Schizo Substance Use Disor -There was no current Interview on 11/15/22 -He would check his of to print and add to red	ew and interview the facility of three audited clients (client as completed annually. The of client #2's record revealed: (17/21. affective Bipolar Type and der at treatment plan. with the Director revealed: computer to see if he forgot		Director (me), had to properly place client's File, It available for revi upon request. In Director will assu will be completed in time, signed and as required	in Le w	

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If continuation sheet 3 of 5

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Division of Health Service Regulation

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED
MHL001-187					R
		B. WING		11/16/2022	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY	, STATE, ZIP CODE	
CEESON	IS OF CHANGE		RNINGSIDE		
			TON, NC 2	27217	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE COMPLETE E APPROPRIATE DATE
V 112	Continued From pa	ge 3	V 112		
	current treatment pl -Confirmed the facil was completed ann	ity failed to the treatment plan			
V 736	27G .0303(c) Facilit	y and Grounds Maintenance	V 736		11/21/2=
	104 NCAC 27C 02		V73	6	11/2/1/2/-
	10A NCAC 27G .03 EXTERIOR REQUI				
	(c) Each facility and	its grounds shall be		Refrigetator emptied of all drawers and s	has been
	maintained in a safe	, clean, attractive and orderly		emptied of all	items,
	odor.	kept free from offensive		deminant and s	shelver
	00011			were moved, th	
				were moved, th	voroughly
				washed, clean	ed and
				sanitized, All	questionable
	This Rule is not me			Foods that mig.	L I
		n and interview, the facility ity grounds were maintained			
	in a clean, safe and	attractive manner. The		odors were dis	
	findings are:			Director will c	hecti this
1	Observation on 11/1	6/22 at about 1:57pm of the		weekly,	
	kitchen revealed:	sizz at about 1.57 pin of the		l	
		or of spoiled food when		Sinks and round	ers have 11/22/2.
	opened. -Refrigerator had sta	ins on drawers and shelves.			
	-Stains around sink a			been properly cle	aneo by
-	Window seal dusty a	and blinds dirty and dusty.		Statt, Window.	seals, blinds
	Top of stove greasy Baseboards dirty an			were dusted off	and cleaned
	auto unity all	a adoly.		with soap and	
		6/22 at about 1:59pm of the			111
	dining room area rev Wall had bug- appe	ealed: ared to be a roach crawling		there are no sid	ghiting nor
	oward the ceiling.	and to be a roach clawing		identifiable tra	ices that any
-	Walls were dirty, dus				USt, 2 profession
-	window seal was du	sty with dirty and dusty		treatments conduc	
	1th Service Regulation			9 E	lent roaches.or
TE FORM		689	39 4	3LC11	If continuation sheet 4 of 5
					n invading premise
				Director will C	check this week

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Division of Health Service Regulation

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
******		MHL001-187	B. WING		R 11/16/2022
	PROVIDER OR SUPPLIER	1536 MOI	DDRESS, CITY, RNINGSIDE STON, NC 27		
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETE
	about dining room t -Baseboards dirty a Observation on 11/ hallway area reveal -Walls were stained -Baseboards dirty a Observation on 11/1 bathroom area reve -Walls were dirty. -There was an odor bathroom. - The tub was dirty. Observation on 11/1 outside/carport/back -Lawnmower equipr back side of the hou- -Tools and yard equipr back side of the hou- -Tools and yard equipr back side of the hou- -Tools and yard equipr back side of the front of -Lawn chair blocked enter the house. -Spider webs were of hanging about entra This deficiency has to original cite on Janua corrected within 30 of	In't work in the light fixture table. and dusty. /16/22 at about 2:02pm of the iled: d and dirty and dusty. /16/22 at about 2:05pm of the ealed: r of urine upon entering the 16/22 at about 2:08pm of the ekyard area revealed: ment was cluttered against the use. uipment cluttered in the 16/22 at about 2:12pm of the door entrance revealed: d the doorway entrance to on the door handle and ance way. been cited 3 times since the uary 30, 2019, and must be days.		Wall and windo baseboards have washed and dus The bathroom ha cleaned, with sin and Floor . Floor and client's infor educated on prop and clean liners ra maintain a sanit at all times. Stat this daily Director has met who owns all lawn and tools. Client discard unuscable organized and dec back of home and Lawn chain has be and spiden webs re Director will mon	s been 11/23 ik, bath-tub was mopped med and ler use equired to ary bathroom Fwill check with client equipment agreed to items; clutter from carport, en relocted itered these itered these itered these itered to itered these itered to itered these itered to itered these itered to itered to ite