PRINTED: 06/16/2023 FORM APPROVED

Division of	of Health Service Regu	lation			FORWAPPROVEL	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL011-386	B. WING		06/14/2023	
NAME OF PE	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	, ZIP CODE		
LIVINGSTONE'S HOME		DWIN ROAD , NC 28704				
(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 SHOUL) CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	D BE COMPLETE	
V 000	INITIAL COMMENTS		V 000			
	An annual and follow 6/14/23. A deficiency	up survey was completed was cited.				
	This facility is licensed for the following service category: 10A NCAC 27G Supervised Living for Alternative Family Living.					
	-	d for 3 and currently has a vey sample consisted of ents.				
V 290	27G .5602 Supervise	d Living - Staff	V 290			
	of this Rule shall be denable staff to responseeds. (b) A minimum of one present at all times we premises, except whe habilitation plan docucapable of remaining without supervision. as needed but not less the client continues to the home or commun specified periods of ti (c) Staff shall be presented to the continue of the child or adolescent clients of the children or a shuse disorders shall of one staff present for clients present. How	above the minimum Paragraphs (b), (c) and (d) letermined by the facility to ad to individualized client e staff member shall be hen any adult client is on the en the client's treatment or ments that the client is in the home or community The plan shall be reviewed is than annually to ensure to be capable of remaining in ity without supervision for me. Sent in a facility in the action when more than one ient is present: adolescents with substance be served with a minimum or every five or fewer minor rever, only one staff need be				
	present during sleepii	ng hours if specified by the procedures determined by				

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

PRINTED: 06/16/2023 FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` '	(X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRU		
		MHL011-386	B. WING		0.0	214 412022
					00	6/14/2023
NAME OF P	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE	, ZIP CODE		
LIVINGST	ONE'S HOME		DWIN ROAD NC 28704			
	CHMMADVCT			PROVIDER'S PLAN OF	F CORRECTION	0.50
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
V 290	developmental disabi one staff present for present and two staff more clients present. need be present duri specified by the emel determined by the go (d) In facilities which diagnosis is substand (1) at least one duty shall be trained withdrawal symptoms secondary complicati drug addiction; and	adolescents with lities shall be served with every one to three clients present for every four or However, only one staff ng sleeping hours if rgency back-up procedures everning body. serve clients whose primary se abuse dependency: estaff member who is on in alcohol and other drug is and symptoms of ons to alcohol and other se of a certified substance Il be available on an	V 290			
	failed to ensure the chabilitation plan docucapable of remaining without supervision a #2). The findings are Review on 6/13/23 of Admitted 4/1/03. Diagnoses of Autism Oppositional Defiant and Unspecified Mood-3/10/22 - unsupervisiapproved up to 3 hours	ew and interview, the facility lient's treatment or mented the client was in the home or community ffecting 1 of 2 clients (Client :: Client #2's record revealed: Spectrum Disorder, Disorder, Impulse Disorder				

Division of Health Service Regulation

STATE FORM 6899 66U111 If continuation sheet 2 of 4

Division of Health Service Regulation

DIVISION	n Health Service Negu	iauon				
, ,		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COMPLETED		
						
			B WINC			
		MHL011-386	B. WING		06/1	4/2023
NAME OF P	ROVIDER OR SUPPLIER	STREFT AF	DDRESS, CITY, STA	TE, ZIP CODE		
	- 1-1-1		OWIN ROAD			
LIVINGST	ONE'S HOME					
		ARDEN, I	NC 28704			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP		COMPLETE DATE
TAG	REGULATORT OR I	LGC IDENTIFTING INFORMATION)	TAG	DEFICIENCY)	NAIE	BALL
				, , , , , , , , , , , , , , , , , , ,		
V 290	Continued From page	e 2	V 290			
	. •					
		tered Profile - no treatment				
	-	ent's ability to remain in the				
	home or community u	ınsupervised.				
	Interview on 6/13/23					
	guardian, who was al					
		ble to stay at home alone, up				
	to 2 hours, per the gu					
	-Client was unsure of	how many hours he had				
	approved.					
	-Per the guardian, it h	nad been documented in his				
	treatment plan for "lik	e 7 years now."				
	Interview on 6/13/23 with the AFL provider					
	revealed:					
	-Client #2 had 3 to 4 l	hours of approved				
	unsupervised time.					
	-He spent "maybe 30	minutes" alone at the facility				
	every once in a while	when he got home before				
	anyone else.	•				
	-She believed this wa	is documented in his				
	treatment plan.					
	ı					
	Interview on 6/13/23	with the QP revealed:				
	-She had an updated					
		t #2, but it was in her other				
	office.	t // 2, Sat it was in nor other				
		to have up to 3 hours of				
		•				
		hich included in the home				
	and community.	the two streets because the				
		the treatment plan yet, she				
	-	Program Manager yesterday				
	that this needed to be	e in the plan.				
	Int	with the Due was NA				
		with the Program Manager				
	revealed:					
	-Client #2's unsuperv					
		ust have been deleted.				
	-She would contact th	ne Local Management Entity	1			

Division of Health Service Regulation

and ensure it was put back into the plan.

STATE FORM 6899 66U111 If continuation sheet 3 of 4

PRINTED: 06/16/2023 FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE COMF	(X3) DATE SURVEY COMPLETED	
		MHL011-386	B. WING		06	06/14/2023	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE						17/2023	
LIVINGST	LIVINGSTONE'S HOME 212 BALDWIN ROAD ARDEN, NC 28704						
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION (X5 PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPL			(X5) COMPLETE DATE	

Division of Health Service Regulation

STATE FORM 6899 If continuation sheet 4 of 4 66U111