Division of Health Service Regulation

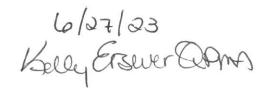
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL011-386			(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED
		MHL011-386			06/14/202
NAME OF P	ROVIDER OR SUPPLIER	STREET	DDRESS, CITY, STATE	E, ZIP CODE	1 00/14/202
LIVINGST	ONE'S HOME	212 BAL	DWIN ROAD		
LIVINGST	ONE S HOME	ARDEN,	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 SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
V 000	INITIAL COMMENTS An annual and follow up survey was completed		V 000		
	6/14/23. A deficiency This facility is licensed category: 10A NCAC Alternative Family Livi	was cited. If for the following service 27G Supervised Living for			
	census of 2. The survaudits of 2 current clie 27G .5602 Supervised	rey sample consisted of ints.	V 290		
	of this Rule shall be de enable staff to respond needs. (b) A minimum of one present at all times who premises, except wher habilitation plan docum capable of remaining in without supervision. To as needed but not less the client continues to	above the minimum Paragraphs (b), (c) and (d) etermined by the facility to d to individualized client staff member shall be en any adult client is on the in the client's treatment or			
£ 6	specified periods of time (c) Staff shall be present following client-staff rate child or adolescent clied (1) children or acceptable disorders shall be of one staff present for clients present. Howe present during sleeping	ne. ent in a facility in the cios when more than one		DHSR - Mental JUL 0 5 202 Lic. & Cert. Ser	3

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PRINTED: 06/16/2023 FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ MHL011-386 B. WING 06/14/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 212 BALDWIN ROAD LIVINGSTONE'S HOME **ARDEN, NC 28704** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) V 290 Continued From page 1 V 290 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: 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. Unsupervised time This Rule is not met as evidenced by: Based on record review and interview, the facility has now been added failed to ensure the client's treatment or to consumer's ISPby habilitation plan documented the client was capable of remaining in the home or community the Care Coordinator without supervision affecting 1 of 2 clients (Client #2). The findings are: m VAYA MCO. All Review on 6/13/23 of Client #2's record revealed: being trained to -Admitted 4/1/03. assure this information -Diagnoses of Autism Spectrum Disorder,

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Professional (QP).

Oppositional Defiant Disorder, Impulse Disorder

-3/10/22 - unsupervised time assessment approved up to 3 hours - includes home and community time - completed by the Qualified

and Unspecified Mood Disorder.

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appears in all ISPs.

24 person will perform

this is completed Q Avisit

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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 P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE					
LIVINGSTONE'S HOME 212 BALDWIN ROAD ARDEN, NC 28704									
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT	TION!				
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRODEFICIENCY)	ION SHOULD BE COMPLETE HE APPROPRIATE DATE				
V 290	Continued From page 2		V 290						
	goal indicating the clie home or community un								
	to 2 hours, per the gua- -Client was unsure of happroved.	o present, revealed: le to stay at home alone, up							
	treatment plan for "like Interview on 6/13/23 w revealed:	7 years now."							
	-Client #2 had 3 to 4 he unsupervised time. -He spent "maybe 30 n	ninutes" alone at the facility when he got home before							
	officeThe client continued to unsupervised time, whi and communityShe had not put it in the	nsupervised time #2, but it was in her other have up to 3 hours of ch included in the home te treatment plan yet, she rogram Manager yesterday							
	revealed: -Client #2's unsupervise treatment plan and mus	t have been deleted. Local Management Entity							

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Kerly Ersuer Comma 10/27/23

Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: __ MHL011-386 B. WING_ 06/14/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 212 BALDWIN ROAD LIVINGSTONE'S HOME **ARDEN, NC 28704** (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY)

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