

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL078-279	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/18/2023
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NAME OF PROVIDER OR SUPPLIER ROBESON #2	STREET ADDRESS, CITY, STATE, ZIP CODE 104 EAST GERTRUDE STREET FAIRMONT, NC 28340
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(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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 000	<p>INITIAL COMMENTS</p> <p>An annual survey was completed on August 18, 2023. A deficiency was cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities.</p> <p>The facility is licensed for 6 and currently has a census of 6. The survey sample consisted of audits of 3 current clients.</p>	V 000		
V 111	<p>27G .0205 (A-B) Assessment/Treatment/Habilitation Plan</p> <p>10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN</p> <p>(a) An assessment shall be completed for a client, according to governing body policy, prior to the delivery of services, and shall include, but not be limited to:</p> <ol style="list-style-type: none"> (1) the client's presenting problem; (2) the client's needs and strengths; (3) a provisional or admitting diagnosis with an established diagnosis determined within 30 days of admission, except that a client admitted to a detoxification or other 24-hour medical program shall have an established diagnosis upon admission; (4) a pertinent social, family, and medical history; and (5) evaluations or assessments, such as psychiatric, substance abuse, medical, and vocational, as appropriate to the client's needs. <p>(b) When services are provided prior to the establishment and implementation of the treatment/habilitation or service plan, hereafter referred to as the "plan," strategies to address the client's presenting problem shall be documented.</p>	V 111		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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V 111	<p>Continued From page 1</p> <p>This Rule is not met as evidenced by: Based on record review and interview, the facility failed to complete an assessment prior to admission affecting one of three audited clients (#1). The findings are:</p> <p>Review on 8/18/23 of client #1's record revealed: -28 year-old male. -Moved into the facility from a sister facility on 12/12/22. -Diagnoses included intellectual developmental disability (mild), insomnia, vitamin D deficiency, hyperlipidemia, and gastroesophageal reflux disease. -No initial assessment completed prior to client #1's admission to the facility from a sister facility.</p> <p>Interview on 8/18/23 the Administrator stated: -Client #1 was previously a resident in an alternative/assisted family living facility operated under the current licensee. -Client #1 transferred to the current facility on 12/12/22. -She would make sure an admission assessment/discharge was completed for any future clients moved from one sister facility to another.</p>	V 111		