AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED	
		MHL067-210				R 09/29/2023
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
SUFFOL	K HOUSE		FOLK CIRCLE NVILLE, NC 2	8546		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
V 000	INITIAL COMMENT	ſS	V 000			
	An annual and follow up survey was completed on September 29, 2023. Deficiencies were cited.					
	This facility is licensed for the following service category 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities.					
		sed for 3 and currently has a rvey sample consisted of clients.				
V 112	27G .0205 (C-D) Assessment/Treatn	nent/Habilitation Plan	V 112			
	10A NCAC 27G .02 TREATMENT/HAB PLAN	05 ASSESSMENT AND				
	assessment, and in legally responsible					
	(1) client outcome(s) that are anticipated to be on of the service and a chievement;				
	 (4) a schedule for r annually in consulta responsible person (5) basis for evaluation 	review of the plan at least ation with the client or legally or both; ation or assessment of				
	responsible party, o	ent; and or agreement by the client or or a written statement by the y such consent could not be				

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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	
		IDENTIFICATION NUMBER.	A. BUILDING:			
		MHL067-210	B. WING			R 29/2023
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
SUFFOL	K HOUSE					
			NVILLE, NC 2		CORRECTION	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLETE DATE
V 112	Continued From pa	ge 1	V 112			
	This Pula is not me	at as ovidenced by:				
	This Rule is not me Based on record re	views and interview the facility	,			
	failed to obtain writt	en consent or agreement for				
		tation or service plan by the person for 1 of 3 current				
	clients (#3). The fin					
	D					
	revealed:	3 of client #3's record				
	- 52 year old male a					
		ed Intellectual/Developmental				
		chizophrenia, paranoid type; ury; Dementia due to anoxia.				
	- Guardianship esta	blished 11/17/20.				
		Plan (ISP) Meeting date				
	- Last guardian sign	date 11/01/23 (incorrect date). ed ISP 09/27/21.				
		rent guardian signature.				
		n 09/29/23 the Residential				
	Administrator stated	a: client #3 was a local advocacy				
	group.					
	- The individual gua	rdian assigned to client #3's				
	case had changed.	up on the signatures for				
	treatment plans.	ap on the signatures ion				
	This deficiency con	stitutes a re-cited deficiency				
	and must be correc					

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STATEMENT OF DEFICIENCIES (X'AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
	MHL067-210		B. WING			R 09/29/2023	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE			
SUFFOL	K HOUSE						
			NVILLE, NC 2		CORRECTION	()(5)	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE	
V 291	Continued From pa	ge 2	V 291				
V 291	27G .5603 Supervis	sed Living - Operations	V 291				
	six clients when the developmental disa on June 15, 2001, a than six clients at th provide services at licensed capacity. (b) Service Coordin maintained between qualified profession treatment/habilitatio (c) Participation of Responsible Person provided the opport relationship with he means as visits to t the facility. Reports annually to the pare legally responsible Reports may be in conference and sha progress toward me (d) Program Activiti activity opportunitie needs and the treat Activities shall be d inclusion. Choices or legal system is in	cility shall serve no more than a clients have mental illness or ibilities. Any facility licensed and providing services to more nat time, may continue to no more than the facility's mation. Coordination shall be in the facility operator and the ials who are responsible for on or case management. the Family or Legally in. Each client shall be sunity to maintain an ongoing r or his family through such he facility and visits outside is shall be submitted at least ent of a minor resident, or the person of an adult resident. writing or take the form of a all focus on the client's eeting individual goals. ies. Each client shall have s based on her/his choices, tment/habilitation plan. esigned to foster community may be limited when the courn hvolved or when health or ne a primary concern.					
	Based on record re failed to coordinate	view and interviews the facility medical services with other possible for client's treatment fo					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				COM	E SURVEY PLETED
	MHL067-210	B. WING			R 29/2023
PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
K HOUSE					
(EACH DEFICIENC)	MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
Continued From pa	ge 3	V 291			
one of three audited	d clients (#1). The findings are:				
revealed: - 50 year old female - Admission date of - Diagnoses include Disability, moderate Disorder. - No documentation	e. 12/30/19. ed Intellectual/Developmental e; Schizophrenia; and Seizure n of Physical Therapy (PT) for				
Consultation Evalua revealed: - Date of visit: 07/01 - Name of consulta - "Purpose of visit: 1 - "New Medication I regiment (Please lis Therapy 2-3 x (time - next appointment	ation Form" for client #1 7/23. nt: Therapist was checked. PT." Prescribed or Change in st below) Attend Physical s) I wk (week) for 4-6 wks." 07/21/23.				
#1 for falls or poten - 09/22/23, 09/21/23	tial for falls revealed: 3, 08/28/23, 08/16/23,				
Administrator stated - Client #1 had sen - Client #1's guardia authorization for se done on 07/21/23. - Client #1 had COV stay later that same - The facility had be	d: a therapist on 07/07/23. an had not signed an rvices and no therapy was /ID in August and a hospital e month. een dealing with internal health				
	OF CORRECTION PROVIDER OR SUPPLIER K HOUSE SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From pa one of three audited Review on 08/31/22 revealed: - 50 year old female - Admission date of - Diagnoses include Disability, moderate Disability, moderate Disorder. - No documentation client #1 after 07/07 Review on 09/28/23 Consultation Evalua revealed: - Date of visit: 07/07 Name of consulta - "Purpose of visit: 1 - "New Medication I regiment (Please lis Therapy 2-3 x (time - next appointment - Illegible signature Review on 09/28/23 #1 for falls or poten - 09/22/23, 09/21/23 Mater that same - Client #1 had sen - Client #1 had sen - Client #1 had sen - Client #1 had cov stay later that same - The facility had be	OF CORRECTION IDENTIFICATION NUMBER: MHL067-210 MHL067-210 ROVIDER OR SUPPLIER STREET AC K HOUSE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 3 one of three audited clients (#1). The findings are: Review on 08/31/22 of client #1's record revealed: 50 year old female. Admission date of 12/30/19. Diagnoses included Intellectual/Developmental Disability, moderate; Schizophrenia; and Seizure Disorder. No documentation of Physical Therapy (PT) for client #1 after 07/07/23. Review on 09/28/23 of a facility "Medical Consultation Evaluation Form" for client #1 revealed: Date of visit: 07/07/23. Name of consultant: Therapist was checked. "Purpose of visit: PT." - New Medication Prescribed or Change in regiment (Please list below) Attend Physical Therapy 2-3 x (times) I wk (week) for 4-6 wks." - next appointment 07/21/23. Illegible signature dated 07/07/23. Review on 09/28/23 of incident reports for client #1 for falls or potential for falls reveal	OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: MHL067-210 B. WING PROVIDER OR SUPPLIER STREET ADDRESS, CITY, S' XHOUSE 131 SUFFOLK CIRCLE JACKSONVILLE, NC 2 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG Continued From page 3 V 291 one of three audited clients (#1). The findings are: V 291 Review on 08/31/22 of client #1's record revealed: V 291 - 50 year old female. - Admission date of 12/30/19. - Diagnoses included Intellectual/Developmental Disability, moderate; Schizophrenia; and Seizure Disorder. No documentation of Physical Therapy (PT) for client #1 after 07/07/23. Review on 09/28/23 of a facility "Medical Consultation Evaluation Form" for client #1 revealed: - - Date of visit: 07/07/23. Name of consultant: Therapist was checked. - "Purpose of visit: PT." - "New Medication Prescribed or Change in regiment (Please list below) Attend Physical Therapy 2-3 x (times) I wk (week) for 4-6 wks." - next appointment 07/21/23. Illegible signature dated 07/07/23. Review on 09/28/23 of incident reports for client #1 for falls or potential for falls revealed: - 09/22/23, 09/21/23, 08/28/23, 08/16/23, 08/04/23, 07/31/23, 07/24/23 and 07/19/23. Interview on 09/29/29/3 the Residenti	OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: MHL067-210 B. WING *ROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE SUMMARY STATEMENT OF DEFICIENCIES ID VEROVIDER OR LICE INCLES ID SUMMARY STATEMENT OF DEFICIENCIES ID REQULATORY OR LISC IDENTIFYING INFORMATION) ID Continued From page 3 V 291 One of three audited clients (#1). The findings are: ID Review on 08/31/22 of client #1's record revealed: - 50 year old female. - Admission date of 12/30/19. - Diagnoses included Intellectual/Developmental Disorder. No documentation of Physical Therapy (PT) for client #1 after 07/07/23. Review on 09/28/23 of a facility "Medical Consultant: Therapist was checked. - "Purpose of visit: PT." - Name of consultant: Therapist was checked. - "Purpose of visit: PT." - New Medication Prescribed or Change in regiment (Please list below) Attend Physical Therapy 2-3 x (times) I wk (week) for 4-6 wks." - next appointment 07/21/23. Review on 09/28/23 of incident reports for client #1 for falls revealed: - 09/22/23, 09/21/23, 07/24/23 and 07/19/23. Interview on 09/29/23 the Residential Administrator stated: - Olient #1 had sen a therapist on 07/07/23. Client #1 had	OF CORRECTION IDENTIFICATION NUMBER: A BUILDING: COM MHL067-210 B. WING 089 PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 131 SUFFOLK CIRCLE JACKSONVILLE, NC 28546 JACKSONVILLE, NC 28546 PROVIDERS PLAN OF CORRECTION SHOULD BE IN FULL REQUARTORY ON LSC IDENTIFYING INFORMATION PRETEX CROSS-REFERENCE Continued From page 3 V 291 PROVIDERS PLAN OF CORRECTION SHOULD BE INFORMATION Continued From page 3 V 291 one of three audited clients (#1). The findings are: CROSS-REFERENCE Review on 08/31/22 of client #1's record revealed: -50 year old female. - 50 year old female. - Admission date of 12/30/19. - Disponder. No documentation of Physical Therapy (PT) for client #1 free 07/07/23. Review on 09/28/23 of a facility "Medical Consultation Evaluation Form" for client #1 revealed: - Name of consultant: Therapist was checked. - "Purpose of visit: D7/07/23. Review on 09/28/23 of incident reports for client #1 reports or state: - New decisito Prescribed or Change in regiment (Please list below) Attend Physical Therapy 2-3 x (times) I wk (week) for 4-6 wks." - next appointment 07/21/23. OR/26/23, 08/16/23, 08/16/23, 08/16/23, 08/16/23, 08/16/23, 08/16/23, 08/16/23, 08/16/23, 08/16/23, 08/16/23, 08/16/23, 08/16/23, 08/16/23, 08/

STATE FORM

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If continuation sheet 4 of 5

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
			A. BUILDING:		R	
		MHL067-210	B. WING			R 29/2023
IAME OF I	PROVIDER OR SUPPLIER		ADDRESS, CITY, ST			
UFFOL	K HOUSE		FOLK CIRCLE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
V 291	Continued From pa	ge 4	V 291			
	appointments.	-				

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