STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED 02/22/2024		
		MHL001-277					
NAME OF	PROVIDER OR SUPPLIER		DDRESS, CITY, STATE, ZIP CODE			· · · · · · · · · · · · ·	
ABUNDA	NT CARE HOMES, L		AST WEBB AN TON, NC 272				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	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	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
V 000	INITIAL COMMENTS		V 000				
	An annual survey was completed on February 22, 2024. Deficiencies were cited.						
	This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disability.						
		sed for 6 and currently has a urvey sample consisted of clients.					
V 290	27G .5602 Supervised Living - Staff		V 290				
	numbers specified of this Rule shall be enable staff to resp needs. (b) A minimum of co present at all times premises, except w habilitation plan doo capable of remainin without supervision as needed but not I the client continues the home or comm specified periods of (c) Staff shall be pu following client-staff child or adolescent (1) children of abuse disorders sh of one staff present clients present. Ho present during slee	bes above the minimum in Paragraphs (b), (c) and (d) e determined by the facility to ond to individualized client one staff member shall be when any adult client is on the when the client's treatment or cuments that the client is ng in the home or community . The plan shall be reviewed ess than annually to ensure to be capable of remaining in unity without supervision for f time. resent in a facility in the f ratios when more than one client is present: or adolescents with substance all be served with a minimum t for every five or fewer minor powever, only one staff need be ping hours if specified by the p procedures determined by					

STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		egulation (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED 02/22/2024				
		MHL001-277							
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1009-A EAST WEBB AVENUE									
ABUNDA	ANT CARE HOMES, L		EAST WEBB AN GTON, NC 272	-					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	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	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE			
V 290	 Continued From page 1 (2) 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: (1) 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. 		V 290						
	facility failed to ass three audited client unsupervised in the findings are:	views and interviews, the ess the capability for two of							
	record revealed: -Admission date of -Diagnoses of Decr Borderline Persona Herniation, Schizoa Lower Extremities a Disease. -No documentation								

STATE FORM

2WG211

AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED				
		MHL001-277	B. WING	B. WING		22/2024			
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1009-A EAST WEBB AVENUE									
ABUNDA	ANT CARE HOMES, L		EAST WEBB AN GTON, NC 272						
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y 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 THE APPROPRIATE	(X5) COMPLET DATE			
V 290	Continued From page 2		V 290						
	home or community.								
	record revealed: -Admission date of -Diagnoses of Deci Borderline Persona Hyperplasia, Schize Use Disorder, Chro Disease, Hyperlipio Reflux Disease, Ne (upon standing) an -No documentation	reased Intellectual Functioning lity Disorder, Benign Prostatic paffective Disorder, Tobacco onic Obstructive Pulmonary lemia, Gastroesophageal europathy, Low Blood Pressure d Hypothyroidism. the facility assessed client ave unsupervised time in the							
	-He had unsupervis -He walked to a sto -He walked by hims -He had been walk	4 with client #1 revealed: sed time in the community. ore in the area once a week. self most of the time. ing to the store in the area a little over six months."							
	-He goes out in the about once a week -He walked to a sto facility.	ore across the street from the ow long he had been walking							
	-Clients #1 and #3 community and in t -They walked to a s -They walked to the -The store was acr -They were gone a	store near the facility. e store about once a week. oss the street from the facility.							

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AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED	
		NUL 004 077				
		MHL001-277			02/	22/2024
IAME OF I	PROVIDER OR SUPPLIER		DRESS, CITY, ST AST WEBB A			
BUNDA	ANT CARE HOMES, L		TON, NC 272			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y 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 290	Continued From page 3		V 290			
	father about the un- -The unsupervised she knew. -Client #1 and #3 "r unsupervised time -She confirmed the capability for clients unsupervised time Interview on 2/22/2 -He didn't allow clie store alone whenew -He walked with the -He didn't know the unsupervised. -He recalled staff # client #1's father giv the store. -He confirmed the f capability for clients	time was approved as far as really" don't use the in the home. facility failed to assess the s #1 and #3 to have in the home or community. 4 with the Manager revealed: ents #1 and #3 to walk to the ver he worked with them.				

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