STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL052-001	A. BUILDING: _____ B. WING _____	R 02/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JONES COUNTY HOME	2280 OAK GROVE ROAD TRENTON, NC 28585

(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	INITIAL COMMENTS An annual and follow up survey was completed on February 14, 2024. A deficiency was cited. The facility is licensed for: 10A NCAC 27G .5600C Supervised Living for Adults wit Developmental Disabilities. This facility is licensed for 6 and currently has a census of 6. The survey sample consisted of audits of 3 current clients.	V 000		
V 112	27G .0205 (C-D) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (c) The plan shall be developed based on the assessment, and in partnership with the client or legally responsible person or both, within 30 days of admission for clients who are expected to receive services beyond 30 days. (d) The plan shall include: (1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement; (2) strategies; (3) staff responsible; (4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both; (5) basis for evaluation or assessment of outcome achievement; and (6) written consent or agreement by the client or responsible party, or a written statement by the provider stating why such consent could not be obtained.	V 112		

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V 112	Continued From page 1 This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to obtain written consent or agreement by the client or responsible party or a written statement by the provider stating why such consent could not be obtained for 2 of 3 audited clients (#1, #3). The findings are: Finding #1 Review on 2/13//24 of client #1's record revealed: -26 year old male. -Admitted on 12/5/23 -Diagnoses of Bipolar-Unspecified, Generalized Anxiety Disorder, Autistic Disorder and Attention Deficit Hyperactivity Disorder -Treatment plan dated 12/8/23 was not signed by client #1's responsible party. Interview on 2/14/24 client #1 stated he liked living at the facility. Finding #2 Review on 2/13/24 of client #3's record revealed: -34 year old male admitted 6/26/11. -Diagnoses of Autistic Disorder, Hypertension, Hyperlipidemia, Chronic Ear Infection and Adaptive Skills Deficit. -Treatment plan dated 10/17/23 was not signed by client #3's responsible party. Interview on 2/14/24 client #3 stated he liked living at the facility.	V 112		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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V 112	Continued From page 2 Interview on 2/14/23 the Residential Manager stated: -Client #1's guardian had previously signed his treatment plan but she could not locate the signature page. -Client #1's guardian was to sign his treatment plan again on 2/14/24. -She could not locate a signature page for client #3's treatment plan. Interview on 2/14/23 the Residential Director stated the Qualified Professional (QP) was out sick. The QP was responsible for completing the treatment plan and obtaining signatures. She had no way of knowing if the QP had obtained the signatures or not.	V 112		