Division of Health Service Regulation

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
,		1521111110/1110111011152111	A. BUILDING: _		00 22.120
		MHL041-977	B. WING		02/26/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE	
BRENTWO	OOD GROUP HOME		NTWOOD STRI NT, NC 27263	EET	
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECTION	N (X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
V 000	INITIAL COMMENTS		V 000		
	An annual survey was 2024. Deficiencies we	s completed on February 26, ere cited.			
	-	d for the following service 27G .5600A Supervised Mental Illness.			
	-	d for 6 and currently has a rey sample consisted of ents.			
V 112	27G .0205 (C-D) Assessment/Treatme	nt/Habilitation Plan	V 112		
	10A NCAC 27G .020 TREATMENT/HABILI PLAN	5 ASSESSMENT AND TATION OR SERVICE			
	assessment, and in plegally responsible pe	developed based on the artnership with the client or erson or both, within 30 days			
	of admission for clien receive services beyo (d) The plan shall inc	<u> </u>			
	(1) client outcome(s achieved by provisior projected date of ach				
	(2) strategies;				
	annually in consultation	view of the plan at least on with the client or legally			
	responsible person of (5) basis for evaluation outcome achievement	on or assessment of t; and			
	responsible party, or	or agreement by the client or a written statement by the such consent could not be			
	obtained.				

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Division of Health Service Regulation

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION	(X3) DATE :	
7.1.12 . 2.1.1	5. GGT25.1161.1		A. BUILDING: _			
		MHL041-977	B. WING		02/	26/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE		
DDENTW/	OOD CROUD HOME	2325 BRE	NTWOOD STRI	EET		
DKENIW	OOD GROUP HOME	HIGH PO	NT, NC 27263			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TI DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETE DATE
V 112	Continued From page	e 1	V 112			
	This Rule is not met	as evidenced by:				
Based on record reviews and interviews, the facility staff failed to develop and implement goals						
	and strategies in the clients' treatment plans for 1 of 3 audited clients (client #2). The findings are: Review on 2/23/24 of client #2's record revealed:					
	-An admission date o					
	other Mental Disorder Moderate	phrenia, Insomnia due to r and Tobacco Use Disorder,				
	-Age 33	-1.0/00/40 1.11				
		d 8/22/19 noted "currently hizophrenia, had been				
		ner for the majority of his life,				
		er able to physically or				
		n due to her personal health				
		ircumstances, needs to be ere he can become more				
		e a healthy life style, needs				
	· · · · · · · · · · · · · · · · · · ·	sistent with his activities of				
	daily living, is able to	engage in daily hygiene				
		oing so himself, staff will				
		npt and encourage him to				
		ene regimen and maintain a				
	healthy living environ	ment, is not at risk of ally keeps to himself, spends				
		video games and listening				
		on probation due to a felony				
	_	n contact with his probation				
	-An updated assessm	nent dated 6/15/23 noted				

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DIVISION	of Health Service Regu	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SUF	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLET	ED
		MUI 044 077	B. WING		00/06/	2004
		MHL041-977			02/26/	2024
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
		2325 BR	ENTWOOD STRI	EET		
BRENTW	OOD GROUP HOME		INT, NC 27263			
	OLUMANA DV OT		<u> </u>	DDO///DEDIO DI ANI OF CODDECTION		
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
TAG	,	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE		DATE
				DEFICIENCY)		
1/ 110	0 " 15	0	V 442			
V 112	Continued From page	9 2	V 112			
	"has an extensive his	tory of mental illness and				
		rith previous diagnoses of				
	T	ome anxiety, denies any				
		symptoms are mostly				
		njections, reports no current				
		cates no current efforts in				
		has a history of insomnia				
	and problems with sleep, has a history of					
	inpatient hospitalizations with last being in 2014,					
	reports having no supports in place, states he talks with mom sporadically but has no contact					
		sents with some insight into				
		e of medication in his ability				
		, in March 2016 he was				
	shot with a shotgun th	nat damaged his hip and				
	_	t leg and was hit in the head				
		ry 2016 'got a gun charge'				
	per his mother, is diag	gnosed with Alcohol Use				
	· ·	n sustained remission."				
	-An assessment for u	nsupervised time dated				
	5/4/23 noted "has spe	ent unsupervised time in the				
	home and community	safely with no reported				
	issues. Group Home	staff have to remind him to				
	sign out when leaving	and reporting to staff when				
	he's returned to the h	ome. He should continue to				
	increase and maintain	n knowledge on what				
	activities or jobs in the	e community so he can				
	increase his unsuperv	vised time outside the				
	home."					
	-A treatment plan date	ed 7/6/23 noted "will				
		dence by maintaining his				
		showering, brushing his				
		clean clothing 7 days per				
		rooming his hair and beard				
		vill increase his independent				
	, , , ,	ating in shared group home				
	sanitation responsibili	<u>-</u>				
		n routing for his bedroom,				
		pendent living skills by				
	participating in at leas	st two (20 minutes) physical				

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SI	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLE	ETED
		MHL041-977	B. WING		02/2	6/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, STA	TE, ZIP CODE		
DDENTW/	OOD CROUD HOME	2325 BRE	NTWOOD STRE	ET		
DKENIW	OOD GROUP HOME	HIGH POI	NT, NC 27263			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR	JLD BE	(X5) COMPLETE DATE
				DEFICIENCY)		
V 112	walking, playing bask park with staff or othe work to decrease the smokes to 7 or less p of cigarettes to discou- No goals or strategie	cluding but not limited to etball, going to the local er natural supports and will amount of cigarettes he er day limiting the purchase urage increased smoking."	V 112			
	diagnosis of Alcohol l consumption of alcoh	Jse Disorder and recent ol.				
	report, dated 12/15/2: -"Description of Involve (medication) not give intoxication. Level I: r Incident Time: 1pm to -"Resident (client #2) times' that day, which returned, staff (#1) n intoxicated and broug office. The Group Holhim stumbling, slurrin	vement: [Client #2] Med n due to resident ned error-missed dose. o 8pm." went out to the store 'a few n was unusual. When he oticed he seemed that him into the Manager's me Manager also observed				
	and difficulty staying and receive Trazadon was told this was due told about the danger -"Strategies Develope Manager contacted pregional nurse. PS acconversation with res RN advised to call ph The doctor's office is the voicemail option f selected, it was listed Manager called pharm	standing. As a result, he did to 50mg nighttime dose and to alcohol consumption and s of mixing the two." ted/Corrective Action Taken: rogram supervisor and dvised to have a ident when he was sober. armacy and doctors office. closed on Friday and when				
	Trazadone should be they did not know, ch	administered. They said ecked the manufacturer's it should be fine. The Group				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE S	
		MHL041-977	B. WING		02/2	6/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
BRENTWO	OOD GROUP HOME		ITWOOD STRI IT, NC 27263	EET		
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETE DATE
V 112	Home Manager did no called RN (Registered RN contacted [Pharm separate pharmacist given for 24 hours aft They advised contact Physician) so a stand future instances." Review on 2/26/24 of Manager/Qualified Predescription revealed: -"A Position Description signed by the GHM/CE Essential Job Function of successes, problem the individuals, their ecommunity and develous assist in improvement" Further review of the -"Individual Specific Centre of the devery couple of interest to the development of the service of the content of the service of the devery couple of interest the home with Remind [client #2] that right to drink, alcohol to be consumed in pure dangers of mixing alcohol to the service of the appropriate	ot feel that was correct and d Nurse) who agreed. The acy's name] and spoke to a who agreed it should not be er alcohol consumption. ing the PCP (Primary Care ing order can be made for the Group Home ofessional (GHM/QP)'s job on, dated 11/14/22 and of P "Group Home Manager: ns:Maintains awareness and general attitudes of employers and the ops/implements goals to t as needed in these areas GHM/QP's record revealed: Competency for [client #2] a history of drinking and will months. It seems he will ner store or to [a restaurant]. of not signing out when he eye and ear out for if he out letting staff know. at while he does have the isn't allowed on premises or ablic. Also remind him of the ohol with his medications g, to let us know so we can steps. Do not be judgmental, a choice to consume alcohol	V 112			
	Interview on 2/23/24 v -Used to drink alcoho	with client #2 revealed: I.				

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Division of Health Service Regulation

		A. BUILDING:		COMPI	SURVEY LETED
	MHL041-977	B. WING		02/	26/2024
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STAT	TE, ZIP CODE		
BRENTWOOD GROUP HOME		NTWOOD STRE	ET		
	HIGH POI	NT, NC 27263			
PREFIX (EACH DEFICIENCY MUS	ENT OF DEFICIENCIES T BE PRECEDED BY FULL ENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENT	FION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
V 112 Continued From page 5		V 112			
-"Well, I did drink alcohol but not on the premises. T dependents on home mucl last time I drank was, let r went 4 months without it (a every once and a while" -" When I drink I will find woodswhat I would like t restaurant's name] and I will make the restaurant's name] I ge tell myself I do not need a regular sized oneI also one time and [staff #1] told apologized to her" -First started drinking alcohad previously attended Anonymous) meetings -"The December (2023) in store. [Staff #1] told me not anymore to drinkit was a got home. I was dancing a -" I am buying my own a to limit my alcohol. I see not drinking one or two beers. here" -" I congratulated mysel wanted to drink alcohol, but cokeI was proud of mys. Interview on 2/23/24 with some conditions and said here was going to the street at the light). He was working the day client #2]I worked 6am to street at the light). He was working the day client #2 was going to the street at the light). He was working the day when he came back. He was working he was solurred, he was working the was working the day.	the amount I drink th money I have. The me think, a month ago. I alcohol). I just drink d a spot in the o do is to go to [a went there once to drink of beers at [a t small beers I will big beer, just a small, drank at the gas station d me not to I thol in high school AA (Alcoholics cident. I was at the of to go to the store embarrassing when I and she saw me" alcohol, and I am trying othing wrong with No one else drinks f yesterday because I ut instead I bought a elf" staff #1 revealed: of the incident with[to 10pm and it was a facility) late afternoon. if that. He signed out the store (right down the gone for a while. vas staggering, his	V 112			

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
		MHL041-977	B. WING		02/26/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
		2325 BRE	NTWOOD STRI	EET	
BRENTWO	OOD GROUP HOME		NT, NC 27263		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	DN (X5)
PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	D BE COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROF DEFICIENCY)	RIATE DATE
				52.78.2.79	
V 112	Continued From page	e 6	V 112		
	act like he was okav.	I smelled alcohol on his			
		as working that day alsoso			
		has been drinking. He told			
	me he saw some of his friends at the store and took a couple of sips and that was it. I knew it				
	was more than a sip. He was all over the place"				
	-Staff #1 and the GHM/QP spoke with client #2 about his drinking -"We told him he could not have his medication that night." -"This was the only time I am aware that he drank. I know he used to be a drinkerhe				
	apologized the next d				
		hat stood around at the store			
	drinking alcohol.				
	_	for [client #2] to get alcohol			
	to drink while at the s	tore"			
	Interviews on 2/23/24	and 2/26/24 with the			
	GHM/QP revealed:	and 2/26/21 with the			
	-A responsible for wri	ting the clients' treatment			
	plans				
	3	ent plans annually and as			
	needed	agnosis of Alcohol Health 4			
	that was several year	agnosis of Alcohol Use but			
	•	eatment team and discuss			
	adding a goal for clier				
V 290	27G .5602 Supervise	d Living - Staff	V 290		
	10A NCAC 27G .560	2 STAFF			
	(a) Staff-client ratios	= -::::			
		Paragraphs (b), (c) and (d)			
		determined by the facility to			
		nd to individualized client			
	needs.				
	(b) A minimum of one	e staff member shall be			
	present at all times w	hen any adult client is on the			

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Division	of Health Service Regu	lation	_		
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
			_		
		MHL041-977	B. WING		02/26/2024
NAME OF PI	ROVIDER OR SUPPLIER	STREETAL	DRESS, CITY, STA	II E, ZIP CODE	
DDENTW/	OOD CROUD HOME	2325 BRE	NTWOOD STRI	EET	
DKENIW	OOD GROUP HOME	HIGH POI	NT, NC 27263		
0/10/15	STIMMADV ST	ATEMENT OF DEFICIENCIES	15	PROVIDER'S PLAN OF CORRECTION	d 0(5)
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD	(710)
TAG	,	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR	
				DEFICIENCY)	
V 290	Continued From page	e 7	V 290		
		en the client's treatment or			
	•	ments that the client is			
	capable of remaining	in the home or community			
	without supervision.	The plan shall be reviewed			
	as needed but not les	s than annually to ensure			
		be capable of remaining in			
		ity without supervision for			
	specified periods of ti				
	(c) Staff shall be present in a facility in the				
	following client-staff ratios when more than one				
	child or adolescent cl	•			
	()	adolescents with substance			
	abuse disorders shall	be served with a minimum			
	of one staff present for	or every five or fewer minor			
	clients present. How	ever, only one staff need be			
	-	ng hours if specified by the			
		procedures determined by			
	the governing body; of	-			
		adolescents with			
	` '	lities shall be served with			
	•				
		every one to three clients			
	•	present for every four or			
	•	However, only one staff			
	need be present durir				
	specified by the emer	gency back-up procedures			
	determined by the go	verning body.			
	(d) In facilities which	serve clients whose primary			
	diagnosis is substanc	e abuse dependency:			
		staff member who is on			
	\ <i>\</i>	n alcohol and other drug			
	withdrawal symptoms				
		ons to alcohol and other			
		ons to alconor and other			
	drug addiction; and				
	` '	of a certified substance			
	abuse counselor shal				
	as-needed basis for e	each client.			
			1	I .	1

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING			
		MHL041-977	B. WING		02/2	6/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
BRENTWO	OOD GROUP HOME		NTWOOD STRI NT, NC 27263	EET		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETE DATE
V 290	Continued From page	e 8	V 290			
	interviews, the facility treatment plans, the oremaining in the home supervision for specifications of 3 clients (#1, #2 and #3 they had unsupervised in the facility revealed and the supervisions on 2/23 of the facility revealed and the supervisional (GHM/Q Interview on 2/23/24 and The Group Home Materials (GHM/Q Interview on 2/23/24	ns, record reviews and If failed to document, in the Islients' capability of e or community without ied periods of time affecting and #3). The findings are: 1/24 from 8:55am to 9:17am d: Int or side doors 1/24 from 9:18am to 9:22am d: e facility in the agency's van. In anager/Qualified IP) arrived at the facility with the GHM/QP revealed: were inside the facility as define.				
	-An admission date o -Diagnoses of Attention Disorder (ADHD), Co	on Deficit Hyperactivity mbined, Unspecified rum and Other Psychotic				
	-An updated assessm "would like to be more with completing his de home, reports being f was angry at times ar others and was easily shameful to admit the them now, sometimes	nent, dated 10/10/23 noted e responsible, has difficulties aily chores at the group fidgety at times, as a child he and got into fights, annoyed of annoyed, appears ase behaviors and denies as has difficulties falling atting at times, his home				

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STATEMEN [*]	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SU COMPLE	
		MHL041-977	B. WING		02/26	6/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE ZIP CODE		·
			NTWOOD STRE			
BRENTWOOD GROUP HOME			NT, NC 27263			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
V 290	Continued From page	9	V 290			
	burned down when he hearing voices from the hearing voices from the by medications, reporfriendly or neutral Interpretation of the providers and advocational and analysis of Schizo of Sc	e was a child, reports ne attic, currently controlled ts the voices sounded one, last heard voices 12 na job and getting his life trant to him, multiple ons, has been in group oe 2009, no crisis in the last na head injury at the age of ead on a tree and received ack direction in what he life and continues to have ny hygiene and independent ased his socialization skills I supports." ed 6/16/23 noted "will dence and improve his maining a daily hygiene brushing his teeth and es daily as well as washing regularly, will increase his otional state and mental by appropriately expressing aff member or other case ting for appropriate levels of independent living skills by d group home sanitation as well as establish and routine for his bedroom," client #1's ability to remain unity for specified periods of olan client #2's record revealed:				

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-An assessment dated 8/22/19 noted "currently

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	CONSTRUCTION		SURVEY PLETED
	MHL041-977	B. WING		02	/26/2024
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STAT	ΓE, ZIP CODE		
BRENTWOOD GROUP HOME		NTWOOD STRE	ET		
	HIGH POI	NT, NC 27263			
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE / CROSS-REFERENCED 1 DEFICII	ACTION SHOULD BE FO THE APPROPRIATE	(X5) COMPLETE DATE
V 290 Continued From page	e 10	V 290			
has a diagnosis of Soresiding with his mother is not long financially support hir issues and financial or in an environment who independent and have reminders to stay condaily living, is able to routine, but lacks in deed to verbally promous keep up with his hygichealthy living environ harming himself, usual time drawing, playing to music, is currently charge, has to keep in officer." -An updated assessment has an extensive his treatment, presents we schizophrenia and sorecent psychosis and controlled by Invegation employment, and problems with sleinpatient hospitalization reports having no suptalks with mom sporal with other family, presymptoms and the usto manage symptoms shot with a shotgun the sciatic nerve in his leif with a gun, in Februal per his mother, is dia Disorder, Moderate, in stay of the support of the s	chizophrenia, had been her for the majority of his life, er able to physically or in due to her personal health hircumstances, needs to be here he can become more end a healthy life style, needs his istent with his activities of engage in daily hygiene oing so himself, staff will help and encourage him to hene regimen and maintain a ment, is not at risk of hally keeps to himself, spends wideo games and listening on probation due to a felony in contact with his probation hent dated 6/15/23 noted tory of mental illness and with previous diagnoses of himself, reports no current cates no current efforts in has a history of insomnia	V 290			

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MHL041-977 B. WING B. WING O2/26/2024 NAME OF PROVIDER OR SUPPLIER BRENTWOOD GROUP HOME CX4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)	STATEMENT OF DEFICIENCIE AND PLAN OF CORRECTION	ES (X1) PROVIDER/SUPPLIER/CLIA	EMENT OF			CONSTRUCTION	(X3) DATE S	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2325 BRENTWOOD STREET HIGH POINT, NC 27263 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) V 290 Continued From page 11 home and community safely with no reported issues. Group Home staff have to remind him to sign out when leaving and reporting to staff when he's returned to the home. He should continue to increase and maintain knowledge on what activities or jobs in the community so he can increase his unsupervised time outside the	74.15 - 274.1 01 0014.12011011				A. BUILDING: _			
SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PREFIX TAG COMPLETE DATE V 290 Continued From page 11 V 290		MHL041-977		77	B. WING		02/2	26/2024
CACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Deficiency Must be preceded by Full REGULATORY OR LSC IDENTIFYING INFORMATION) Deficiency Must be preceded by Full Regulatory Or LSC IDENTIFYING INFORMATION) Deficiency Must be preceded by Full Regulatory Or LSC IDENTIFYING INFORMATION) Deficiency Must be preceded by Full Regulatory Or LSC IDENTIFYING INFORMATION) Deficiency Must be preceded to the Appropriate Deficiency Date of the Appropriate Date of t	NAME OF PROVIDER OR SU	PPLIER STREET.	E OF PROV	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
CACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) COMPLETE DATE V 290 Continued From page 11 V 290	DDENTWOOD ODOUD!	2325 BF	NTWOOF	2325 BREN	TWOOD STRE	ET		
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) V 290 Continued From page 11 home and community safely with no reported issues. Group Home staff have to remind him to sign out when leaving and reporting to staff when he's returned to the home. He should continue to increase and maintain knowledge on what activities or jobs in the community so he can increase his unsupervised time outside the	BRENTWOOD GROUP F	HIGH P	NIWOOL	HIGH POIN	Г, NC 27263			
home and community safely with no reported issues. Group Home staff have to remind him to sign out when leaving and reporting to staff when he's returned to the home. He should continue to increase and maintain knowledge on what activities or jobs in the community so he can increase his unsupervised time outside the	PREFIX (EACH	DEFICIENCY MUST BE PRECEDED BY FULL	EFIX	D BY FULL	PREFIX	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T	TION SHOULD BE THE APPROPRIATE	COMPLETE
issues. Group Home staff have to remind him to sign out when leaving and reporting to staff when he's returned to the home. He should continue to increase and maintain knowledge on what activities or jobs in the community so he can increase his unsupervised time outside the	V 290 Continued F	- -rom page 11	/ 290 Cd		V 290			
-A treatment plan dated 7/6/23 noted "will increase his independence by maintaining his personal hygiene by showering, brushing his teeth and putting on clean clothing 7 days per week, washing and grooming his hair and beard at least one a week, will increase his independent living skills by participating in shared group home sanitation responsibilities daily as well as establish and maintain routing for his bedroom, will increase his independent living skills by participating in at least two (20 minutes) physical activities per week including but not limited to walking, playing basketball, going to the local park with staff or other natural supports and will work to decrease the amount of cigarettes he smokes to 7 or less per day limiting the purchase of cigarettes to discourage increased smoking." -No documentation of client #2's ability to remain in the home or community for specified periods of time in the treatment plan Review on 2/23/24 of client #3's record revealed: -An admission date of 6/21/96 -Diagnoses of Bipolar Disorder, Schizophrenia, Hyperlipidemia and Hypertension -Age 51 -An updated assessment dated 12/20/22 noted "has been living in a group home for 25 years, went to the hospital on 12/12/22 'because I got tired of feeling weak. I cut my forearm near the yein, and it made a big mess. When I cut my arm,	home and consisues. Grown sign out when he's returned increase and activities or increase his home." -A treatment increase his personal hyperesonal h	community safely with no reported up Home staff have to remind him to en leaving and reporting to staff when it to the home. He should continue to different maintain knowledge on what jobs in the community so he can a unsupervised time outside the time plan dated 7/6/23 noted "will independence by maintaining his giene by showering, brushing his autting on clean clothing 7 days per ing and grooming his hair and beard a week, will increase his independent by participating in shared group home esponsibilities daily as well as and maintain routing for his bedroom, whis independent living skills by gin at least two (20 minutes) physical or week including but not limited to limited to limited to limited to limited to limite the amount of cigarettes here is to discourage increased smoking." In entation of client #2's ability to remain for community for specified periods of the reatment plan. 2/23/24 of client #3's record revealed: and the properties of the local and the purchase and the purchase are the amount of cigarettes here are also and the purchase are the amount of cigarettes here are also and the purchase are the amount of cigarettes and will rease the amount of cigarettes here. 2/23/24 of client #3's record revealed: and the purchase of Bipolar Disorder, Schizophrenia, mia and Hypertension. 2/23/24 of client #3's record revealed: and the purchase of Bipolar Disorder, Schizophrenia, mia and Hypertension.	ho issisted in the control of the co	ind him to staff when continue to what he can be the will hing his ing his ays per and beard hidependent roup home as bedroom, alls by s) physical hited to he local is and will be enchase smoking." By to remain hid periods of his direvealed: Ophrenia, 22 noted 5 years, use I got near the	V 290			

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DIVISION	ot Health Service Regu	lation					
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN OF CORRECTION IDENTIFICATION NU		IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED		
MHL041-977		B. WING		00/00/0004			
		WITIE041-977			02/26/2024		
NAME OF P	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE						
DDENTW	OOD ODOUD HOME	2325 BRI	ENTWOOD STRI	EET			
DKENIW	OOD GROUP HOME	HIGH PO	INT, NC 27263				
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE COMPLETE		
TAG	REGULATORY OR I	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE	RIATE DATE		
				DEFICIENCY)			
V 290	Continued From page	e 12	V 290				
	assisted him with con	centrating, continues to					
	have problems falling						
		when he lost his job to					
	, ,	ed in 2003 and had a gun					
	_	sented as paranoid during					
	-	ooperative, reports his					
		ating and that he cannot					
		ent and insight, needs					
	, , ,	ent, individual and group					
	_	d increase social supports,					
		rough cognitive behavioral					
		•					
	therapy and motivational interviewing, assist with decreasing depressive symptoms, assist in verbalizing life stressors and help manage delusions." -A treatment plan dated 1/8/24 noted "over the						
		mprove his community					
		ercise his unsupervised					
		nd participating in at least					
		ty/event per month, such as					
	(not limited to) church						
		related events or exercise					
	1	without incident, will use					
		p to research community					
	-	group home social events					
	calendar. Staff will en	courage him to utilize his					
		ervised time in the home					
		Il discuss his outing to					
		incidents or concerns,					
	manager will annually	update the unsupervised					
	time assessment, ma	king adjustments and					
		over the next 12 months,					
	will improve his comn	nunity independence and					
	exercise his unsuperv	vised time by picking out and					
	participating in at leas	st one community					
		nth, will improve his physical					
		y choosing healthy meal					
		epared meals as well as					
		cal activity at least three days					
		e his independent living					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	MHL041-977 B. WING			02/26/2024		
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
BRENTW(OOD GROUP HOME	2325 BRE	NTWOOD STRE	EET		
DICEITIVE	JOB GROOF HOWLE	HIGH POI	NT, NC 27263			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
V 290	Continued From page	e 13	V 290			
V 290	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 13 skills by completing his home shared responsibility and maintaining a daily hygiene routine by showering, changing clean clothes and brushing his -1/11/24 departed 10:40am and no return time listed No documentation of client #3's ability to remain in the home or community for specified periods of time in the treatment plan Review on 2/26/24 of the facility's sign in/out log, from 12/1/23 to 2/26/24, revealed: -Client #1 signed in and out on the following dates and times for unsupervised time in the community: -2/19/24 departed 1:45pm and returned 2:30pm -2/20/24 departed 10:30pm and returned 2/20/24 12pm -2/18/24 departed 10:30am returned 2/15/24 2:30pm -2/14/24 departed at 11a and returned 1pm -2/9/24 departed 3:56am and returned 3:47pm -2/6/24 departed 6:15pm and returned 3:47pm -2/6/24 departed 750am and returned 3:47pm -2/6/24 departed 6:15pm and returned 1pm -1/31/24 departed 750am and returned 3:50pm -1/13/24 departed 3:15pm and returned 3:50pm -1/13/24 departed 10:20am and returned 1pm -1/31/24 departed 3:5pm and returned 3:50pm -1/13/24 departed 10:06am and returned 9:30am -1/10/24 departed 2pm and returned 9:30am -1/10/24 departed 10:10am and returned 9:30am -1/10/24 departed 1:30pm and returned 6pm -1/2/24/23 departed 1:10pm and returned 7pm -1/21/24/23 departed 1:10pm and returned 7pm		V 290			
	-12/16/23 departed 10 -12/12/23 departed 10 11:15am	-				

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-12/11/23 departed 4:10pm and returned 4:30pm

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			
		MHL041-977 B. WING		02/26/2024		
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
BRENTWO	OOD GROUP HOME		ITWOOD STRE	EET		
			IT, NC 27263			
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
V 290	Continued From page	2 14	V 290			1
V 230	-12/9/23 departed 9:4 -12/7/23 departed 10:11:30am -12/5/23 departed 10:11:30am -12/2/23 departed 10:11:30am -12/2/23 departed 10:11:30am -12/1/23 to 2/26/2 -Client #2 signed in a and times for unsuper community: -2/21/24 departed 3:2-2/17/24 departed 9:5-2/10/24 departed 8:5-2/17/24 departed 8:5-1/11/24 departed 8:5-1/11/24 departed 8:5-1/11/24 departed 8:4-1/5/24 departed 8:09-12/29/23 departed 11:30am -12/23/23 departed 11:30am -12/23/23 departed 11:136pm -12/13/23 departed 3:12/7/23 departed 3:12/7/23 departed 7:2-12/9/23 departed 7:5-12/1/23 departed 10:11:15am -12/1/23 departed 10:11:15am -12/1/23 departed 6:00	25am and returned 10:45am 25am and returned 9am 203am and returned 2pm 25am and returned 2pm 25am and returned 2pm 25am and returned 2pm 25am and returned 4pm 25pm and returned 4pm 25pm and returned 4pm 25pm and returned 4pm 25pm and returned 9:15am 25pm and returned 9:30am 25am and returned 4pm 25am and returned 8am 25am and returned 8am 25am and returned 8am 25am and returned 8:30am 25am and returned 8:30am 25am and returned 9:50 25am and returned 8:30am 25am and returned 8:30am 25am and returned 7:15am	V 230			
		9am and returned 9:09am				
	revealed:	with clients #1, #2 and #3				

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
MHL041-977			B. WING			02/26/2024	
	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2325 BRENTWOOD STREET HIGH POINT, NC 27263						
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
V 290	the community -Were not sure how notime they had in the fall literview on 2/23/24 versions. Clients #1, #2 and #3 both the facility and the twas not sure how more time the clients had be community -Client #3 did not accept the community "only in the community only in the community "only in the com	nany hours of unsupervised acility or the community with staff #1 revealed: 3 had unsupervised time in the community any hours of unsupervised oth in the facility and in the tess his unsupervised time in	V 290				

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