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
	MHL092-756	A. BUILDING: ______ B. WING ______	02/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEAVEN SENT GROUP HOME	**3209 WINFIELD COURT RALEIGH, NC 27610**

(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 112	Continued From page 2 -Utilized the day program treatment plans since they had residential goals in them. -The Qualified Professional was to obtain those plans and make sure they were in the home and up to date. -Not aware they did not complete client #2's treatment plan within the 30 days of admission. -Will obtain the client's treatment plans from the day program today. Further interview on 1/30/24 the Licensee stated: -Had received the current treatment plans for client #2, #3, and #5.	V 112	Q.P. and Director will insure that all Clients have Current treatment plans on file with in 30 days of move in. Q.P. and Director will ensure that all clients treatment plans are on site and in medical records at all times. As of 1/30/24 all Current treatment plans and in each resident medical record. We will ensure that plans are current and up to date at all times.	1/30/24 1/30/24

Division of Health Service Regulation
STATE FORM

Jermaine Moore 2/16/24