OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,			E SURVEY PLETED
		A. BUILDING:			
	MHL001-086	B. WING		04/	23/2024
ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
R GROUP HOME					
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T	TION SHOULD BE	(X5) COMPLET DATE
INITIAL COMMEN	TS	V 000			
category: 10A NCA	C 27G .5600C Supervised				
census of 6. The su	urvey sample consisted of				
27G .0202 (F-I) Pe	rsonnel Requirements	V 108			
REQUIREMENTS (f) Continuing educ (g) Employee train provided and, at a following: (1) general organiz (2) training on clien delineated in 10A N 10A NCAC 26B; (3) training to mee client as specified i plan; and (4) training in infect bloodborne pathog (h) Except as perm .5602(b) of this Sub member shall be av times when a client member shall be traincluding seizure m to provide cardiopu trained in the Heim techniques such as	cation shall be documented. ing programs shall be minimum, shall consist of the zational orientation; nt rights and confidentiality as ICAC 27C, 27D, 27E, 27F and to the mh/dd/sa needs of the n the treatment/habilitation ctious diseases and ens. itted under 10a NCAC 27G ochapter, at least one staff vailable in the facility at all t is present. That staff ained in basic first aid nanagement, currently trained ilmonary resuscitation and lich maneuver or other first aid s those provided by Red Cross				
	OF DEFICIENCIES F CORRECTION ROVIDER OR SUPPLIER SUMMARY STA (EACH DEFICIENC' REGULATORY OR L INITIAL COMMENT An annual survey v 2024. Deficiencies This facility is licens category: 10A NCA Living for Adults wit This facility is licens category: 10A NCA Living for Adults wit This facility is licens category: 10A NCA Living for Adults wit This facility is licens (1) general organiz (2) training on client provided and, at a following: (1) general organiz (2) training on client following: (3) training to meet client as specified in plan; and (4) training in infector bloodborne pathog (h) Except as perm 5602(b) of this Sulf member shall be at times when a client member shall be at times when a client to provide cardiopu trained in the Heim techniques such as	OF DEFICIENCIES F CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IDENTIFICATION NUMBER: IDENTIFICATION NUMBER: IDENTIFICATION NUMBER: IDENTIFICATION NUMBER: IDENTIFICATION NUMBER: INITIAL COMMENTS An annual survey statement of DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) INITIAL COMMENTS An annual survey was completed on April 23, 2024. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with 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. 27G .0202 (F-I) Personnel Requirements 10A NCAC 27G .0202 PERSONNEL REQUIREMENTS (f) Continuing education shall be documented. (g) Employee training programs shall be provided and, at a minimum, shall consist of the following: (1) general organizational orientation; (2) training on client rights and confidentiality as delineated in 10A NCAC 27C, 27D, 27E, 27F and 10A NCAC 26B; (3) training to meet the mh/dd/sa needs of the client as specified in the treatment/habilitation plan; and (4) training in infectious diseases and bloodborne pathogens. (h) Except as permitted under 10a NCAC 27G .5602(b) of this Subchapter, at least one staff member shall be available in the facility at all times when a client is present. That staff member shall be available in the facility at all times when a client is present. That staff member shall be available in the facility at all times when a client is present. That staff	OF DEFICIENCIES F CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE A. BUILDING: MHL001-086 B. WING COVIDER OR SUPPLIER STREET ADDRESS, CITY, S RGOUP HOME 2150 HAW RIVER-HOP HAW RIVER, NC 27253 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG INITIAL COMMENTS V 000 An annual survey was completed on April 23, 2024. Deficiencies were cited. V 000 This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities. V 108 This facility is licensed for 6 and currently has a census of 6. The survey sample consisted of audits of 3 current clients. V 108 27G .0202 (F-I) Personnel Requirements V 108 10A NCAC 27G .0202 PERSONNEL REQUIREMENTS (f) Continuing education shall be documented. (g) Employee training programs shall be provided and, at a minimum, shall consist of the following: V 108 (1) general organizational orientation; (2) training to meet the mh/dd/sa needs of the client as specified in the treatment/habilitation plan; and (4) training to infectious diseases and bloodborne pathogens. K) Except as permitted under 10a NCAC 27G .5602(b) of this Subchapter, at least one staff member shall be available in the facility at all times when a client is present. That staff member shall be trained in basic first aid including seizure management, curre	OF DEFICIENCIES (X1) PROVIDERSUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION F CORRECTION IDENTIFICATION NUMBER: A BUILDING: MHL001-086 B. WING B. WING ROVIDER STREET ADDRESS, CITY, STATE, ZIP CODE STREET ADDRESS, CITY, STATE, ZIP CODE ROVIDER OF DEFICIENCIES ID PROVIDER'S PLAN OF SUMMARY STATEMENT OF DEFICIENCIES (REACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG CROSS-REFERENCED OF DEFICIENCIES (REACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG CROSS-REFERENCED OF DEFICIENCIES (REACH DEFICIENCY WAS COMPLETING INFORMATION) PREFIX TAG CROSS-REFERENCED OF DEFICIENCIES (INITIAL COMMENTS V 000 An annual survey was completed on April 23, 2024. Deficiencies were cited. V 000 This facility is licensed for 6 and currently has a census of 6. The survey sample consisted of audits of 3 current clients. V 108 10A NCAC 27G 0202 PERSONNEL REQUIREMENTS V 108 (1) general organizational orientation; (2) fanolypee training programs	F CORRECTION IDENTIFICATION NUMBER: A BUILDING: COM MHL001-086 B. WING 04/ SOVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2150 HAW RIVER, NC 2728 SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION IGAN BY DEPICIENCY REGULATORY OR LSC IDENTIFYING INFORMATION PREFIX PROVIDER'S PLAN OF CORRECTION IGAN BY DEPICIENCY INITIAL COMMENTS V 000 V 000 IDENTIFICATION SUBJECTION OF DEFICIENCIES INITIAL COMMENTS V 000 DEFICIENCY DEFICIENCY INITIAL COMMENTS V 000 IDENTIFICATION SUBJECTION OF DEFICIENCIES DEFICENCY INITIAL COMMENTS V 000 DEFICIENCY DEFICIENCY INITIAL COMMENTS V 000 IDENTIFICATION HAR A CONSTRUCT DEFICIENCY Requere the following service category: 10A NCAC2 27G. 5600C Supervised Living for Adults with Developmental Disabilities. V 108 IDA NCAC2 27G. 0202 PERSONNEL RCQUIERENTS If Continuing education shall be documented. ID NCAC2 27G. 27D, 27E, 27F, and 10A NCAC 27G. 550(16) of the Subchapter, at least one staff member shall be available in the facility at all times when a client is presort. That staff member shall be trained in basic first aid neukin

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		· /	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			
		MHL001-086	B. WING		04/	23/2024
IAME OF F	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	TATE, ZIP CODE		
IAW RIV	ER GROUP HOME		NRIVER-HOP ER, NC 2725	EDALE ROAD 8		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLE DATE
V 108	Continued From pa	age 1	V 108			
	implement policies reporting, investiga	body shall develop and and procedures for identifying, ting and controlling infectious diseases of personnel and				
	Based on record re facility failed to ens trained in First Aid. Review on 4/23/24 revealed: -Date of Hire: 2/9/2	of Staff #5's personnel record				
		a Group Home Co-Manager. lence she had completed				
	Director revealed: -She thought Staff in first aid. -She would be imm	4 with the Human Resources #5 had completed her training nediately registering Staff #5 to				
	Cardiovascular Res	leted the training on suscitation (CPR) and filing en confused and thought the				
	Operations reveale -He did not know th aid was missing.	4 with the Vice President of d: nat Staff #3's training on first that Staff #3 did not have in				

STATE FORM

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If continuation sheet 2 of 5

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION				(X2) MULTIPLE CONSTRUCTION A. BUILDING:		E SURVEY PLETED
		MHL001-086	B. WING		04/	23/2024
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
IAW RIV	ER GROUP HOME		W RIVER-HOP /ER, NC 27258			
(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	TION SHOULD BE	(X5) COMPLET DATE
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 abilities. Any facility licensed and providing services to more nat time, may continue to no more than the facility's nation. Coordination shall be in the facility operator and the hals who are responsible for on or case management. the Family or Legally in. Each client shall be tunity to maintain an ongoing ir or his family through such the 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 is based on her/his choices, tment/habilitation plan. esigned to foster community may be limited when the court hvolved or when health or me a primary concern.				
		views and interviews the rdinate with other qualified				

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STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION				(X2) MULTIPLE CONSTRUCTION A. BUILDING:		E SURVEY PLETED
		MHL001-086		B. WING		23/2024
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
HAW RI	/ER GROUP HOME		/ RIVER-HOP ER, NC 27258	EDALE ROAD		
(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 1 DEFICIENC	TION SHOULD BE	(X5) COMPLETE DATE
V 291	treatment/habilitatic & #2). The findings Review on 4/23/24 -Admisison date of -Diagnoses of Mode Developmental Disa Hypertension; Pre-I Deficiency; Dyslipid Allergies. -FL2 dated 4/15/24 weekly. Review on 4/23/24 Administration Reco February, March ar -There were no rec checks for the mon April. Review on 4/23/24 -Admisison date of -Diagnoses of Autis Generalized Anxiety Intellectual and Dev Moderate; Epilepsy Without Status Epil Hypertension; Aller	on for 2 of 3 audited clients (#1 are: of client #1's record revealed: 12/1/92. erate Intellectual and abilities; Essential Diabetes; Vitamin D emia; Sleep Apnea; Seasonal c check blood pressure of client #1's Medication ord (MAR) for the months of ad April of 2024 revealed: ordings for blood pressure ths of February, March or	V 291			
	months of February revealed: -There were no rec checks for the follow -March = No re	of client #2's MAR for the v, March and April of 2024 ordings for blood pressure wing: cordings on 3/18 and 3/25. vere no recordings for the				

		egulation (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		MHL001-086	B. WING		0.4/	/23/2024	
	/IDER OR SUPPLIER		DDRESS, CITY, ST		04/	23/2024	
	GROUP HOME	2150 HA	W RIVER-HOP	EDALE ROAD			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	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 THE APPROPRIATE	(X5) COMPLET DATE	
Ot fac -TI Int Op -H ha pre -Si M/ -H pre -H	cility's medication here was a blood erview on 4/23/24 perations revealed e was under the i d been recording essure checks. taff were suppose AR the blood press e was not aware essure checks for e acknowledged	 3/24 at about 12:00 pm of the room revealed: pressure monitor on site. 4 with the Vice President of d: impression that facility staff the client's high blood ed to log on the back of the ssure checks for the clients. that there were no high blood r clients #1 and #2. that staff had not recorded the e check readings for clients #1 					

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