AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  MHL016-005			42 170-42107 (200-200)	G:		COMPLETED	
		B. WING			04/17/2024		
NAME OF	PROVIDER OR SUPPLIER	2331 NO		, STATE, ZIP CODE /IEW DRIVE 70			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETE DATE	
V 000	this facility is license category: 10A NCAC Living for Adults with This facility is licens census of 5. The su	as completed on April 17, were cited.  ed for the following service C 27G .5600C Supervised in Developmental Disabilities.  ed for 5 and currently has a rivey sample consisted of	V 000				
census of 5. The survey sample consisted of audits of 3 current clients.  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	The facility QP will ensure that PCPs are reviewed annually an after the plan have been develor written consent will be obtained each client's Legal Guardian, if applicable. The facility QP will kneed of the meeting date, and plan start and end date. This documentation will be complete the PCP and located in Monarce electronic record database curre use. Report will be reviewed monto ensure compliance.	ally and that leveloped, ained from an, if will keep a and the nis apleted on onarch's ecurrently in ed monthly			

PLIER REPRESENTATIVE'S SIGNATURE

Residential Director

4/29/24

MHL016-005  MHL016-005  MHL016-005  STREET ADDRESS, CITY, STATE, ZIP CODE  231 NORTH LAKEVIEW DRIVE  NEWPORT  NEWPORT  NEWPORT  NEWPORT, NC 28570  PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  231 NORTH LAKEVIEW DRIVE  NEWPORT, NC 28570  PROVIDER OR DAY OF CORRECTION BUILDING OF PREFIX TAG  PREFIX TAG  This Rule is not met as evidenced by: Based on record reviews and interview the facility failed to review the plan annually and failed to obtain written consent or agreement for the treatment/habilitation or service plan by the client or legally responsible person for 2 of 3 audited clients (#2 and #5) The findings are.  Review on 04/16/24 and 04/17/24 of client #2's record revealed:  - 81 year old female.  - Admission date of 02/201/20.  - Diagnoses of Anxiety, Vitamin D Deficiency, Moderate Intellectual Developmental Disability, Eczema, Sebortheic Dermattiis of Scalp and Hypertension.  - Person-Centreed Plan (PCP) dated 01/28/22.  - No annual review of PCP.  - No current PCP signed by the client or legally responsible person of 2 gined by the client or legally responsible person of 2 gined by the client or legally responsible person of 2 gined by the client or legally responsible person of 2 gined by the client or legally responsible person of 2 gined by the client or legally responsible person.	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	Con a Commence and a commen	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER  NEWPORT  STREET ADDRESS, CITY, STATE, ZIP CODE  2331 NORTH LAKEVIEW DRIVE  NEWPORT, NC 28570    (X4) ID   SUMMARY STATEMENT OF DEFICIENCIES   TAG   (EACH DEFICIENCY MUST BE PRECEDED BY FULL   TAG   TAG	AND PLAN OF CORRECTION		IDENTIFICATION NUMBER.	A. BUILDING:		COMP	LETED
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NEWPORT   NC 28570   NC 4910   NC 28570   NC 4910   NC 28570   NC 4910   NC 28570   NC 4910	NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
PREFIX TAG  REGULATORY OR LSC IDENTIFYING INFORMATION)  V112  Continued From page 1  This Rule is not met as evidenced by: Based on record reviews and interview the facility failed to review the plan annually and failed to obtain written consent or agreement for the treatment/habilitation or service plan by the client or legally responsible person for 2 of 3 audited clients (#2 and #5) The findings are:  Review on 04/16/24 and 04/17/24 of client #2's record revealed: - 61 year old female Admission date of 02/01/20 Diagnoses of Anxiety, Vitamin D Deficiency, Moderate Intellectual Developmental Disability, Eczema, Seborheic Dematitis of Scalp and Hypertension Person-Centered Plan (PCP) dated 01/28/22 No annual review of PCP No current PCP signed by the client or legally responsible person.  Review on 04/16/24 and 04/17/24 of client #5's record revealed: - 53 year old female Admission date of 11/01/21 Diagnosis of Autiem Spectrum Disorder PCP dated 09/23/22 No annual review of PCP No current PCP signed by the client or legally responsible person.	NEWPO	RT					
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Interview on 04/17/24 the Residential		This Rule is not me Based on record revealled to review the pobtain written conset treatment/habilitatio or legally responsible clients (#2 and #5). Review on 04/16/24 record revealed: - 61 year old female - Admission date of - Diagnoses of Anxie Moderate Intellectual Eczema, Seborrheid Hypertension Person-Centered F - No annual review of - No current PCP signesponsible person.  Review on 04/16/24 record revealed: - 53 year old female Admission date of - Diagnosis of Autism - PCP dated 09/23/2 - No annual review of - No current PCP signesponsible person.	et as evidenced by: views and interview the facility blan annually and failed to ent or agreement for the n or service plan by the client e person for 2 of 3 audited The findings are: and 04/17/24 of client #2's  02/01/20. ety, Vitamin D Deficiency. al Developmental Disability, because Dermatitis of Scalp and Plan (PCP) dated 01/28/22. of PCP. gned by the client or legally and 04/17/24 of client #5's  11/01/21. n Spectrum Disorder. 2. of PCP. gned by the client or legally				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
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V 112	- The previous QP had not completed to - The issues with the and meetings are be	rofessional (QP) stated: nad performance issues and the PCPs as required. e PCPs have been identified eing scheduled with guardians	V 112			
V 290	and meetings are being scheduled with guardians to review updated treatment plans.  27G .5602 Supervised Living - Staff  10A NCAC 27G .5602 STAFF  (a) Staff-client ratios above the minimum numbers specified in Paragraphs (b), (c) and (d) of this Rule shall be determined by the facility to enable staff to respond to individualized client needs.  (b) A minimum of one staff member shall be present at all times when any adult client is on the premises, except when the client's treatment or habilitation plan documents that the client is capable of remaining in the home or community without supervision. The plan shall be reviewed as needed but not less than annually to ensure the client continues to be capable of remaining in the home or community without supervision for specified periods of time.  (c) Staff shall be present in a facility in the following client-staff ratios when more than one child or adolescent client is present:  (1) children or adolescents with substance abuse disorders shall be served with a minimum of one staff present for every five or fewer minor 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; or  (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		V 290	1. The Facility QP will ensure that clients who receive unsupervised will have a current unsupervised clocated in the client's medical recording the QP will document any character the unsupervised time when compart the clients annual PCP.  3. This will be monitored at least annually during the PCP meeting 4. Any revisions needed will be mathat time. If revisions are needed then, QP will note the changes on Revised PCP. This will start imme	time consent ords. nges to bleting date. ade at before the	4/30/24

		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION	(X3) DATE	(X3) DATE SURVEY	
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V 290	Continued From page	ge 3	V 290				
	V 290 Continued From page 3 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 250				
	facility failed to ensu habilitation plan docu capable of remaining supervision for speci reviewed annually af clients (#2). The find Review on 04/16/24 record revealed: - 61 year old female Admission date of (- Diagnoses of Anxie Moderate Intellectual Eczema, Seborrheic Hypertension Person-Centered P- No current PCP to c	riews and interviews, the re a clients' treatment or umented the client was g in the community without lifed periods of time and fecting one of three audited ings are:  and 04/17/24 of client #2's  02/01/20.  ty, Vitamin D Deficiency. I Developmental Disability, Dermatitis of Scalp and  lan (PCP) dated 01/28/22.  document client #2's  g in the community for					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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V 290	Continued From pa	ge 4	V 290			
		pervised Time completed				
	Interview on 04/16/24 client #2 stated: - She had resided at the facility for several years Her aunt was her guardian She worked at a local restaurant Staff take her to her job and drop her off Staff pick her up from her job.  Interview on 04/17/24 the Residential Director /Qualified Professional stated: - The previous QP had performance issues and had not updated the PCP for client #2 She was currently serving as the QP for the facility The issue with the PCP had been identified The facility did not change the unsupervised assessment She was aware the PCP needed to be completed annually and to include client #2's capability of remaining in the community					
	10A NCAC 27G .560 (a) Capacity. A faci six clients when the developmental disable on June 15, 2001, at than six clients at the provide services at n licensed capacity. (b) Service Coordinate maintained between qualified professional	lity shall serve no more than clients have mental illness or bilities. Any facility licensed and providing services to more at time, may continue to so more than the facility's ation. Coordination shall be the facility operator and the als who are responsible for a or case management.	V 291	1. The residential managers will e all services needed for the individuare maintained. 2. Residential managers will ensural appointments are scheduled ar documented in Monarch's current electronic medical record system currently in use effectively immedi 3. Appointments will be monitored monthly when QP is completing m goal assessments.	uals re that nd ately.	4/30/24

Division of Health Service Regulation

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		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
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V 291	Continued From page	ge 5	V 291				
	Responsible Person. Each client shall be provided the opportunity to maintain an ongoing relationship with her or his family through such means as visits to the facility and visits outside the facility. Reports shall be submitted at least annually to the parent of a minor resident, or the legally responsible person of an adult resident. Reports may be in writing or take the form of a conference and shall focus on the client's progress toward meeting individual goals.  (d) Program Activities. Each client shall have activity opportunities based on her/his choices, needs and the treatment/habilitation plan. Activities shall be designed to foster community inclusion. Choices may be limited when the court or legal system is involved or when health or safety issues become a primary concern.  This Rule is not met as evidenced by: Based on record review and interview the facility failed to coordinate medical services with other professionals responsible for client's treatment for one of three audited clients (#5). The findings are						
	record revealed: - 53 year old female Admission date of 7 - Diagnosis of Autism - 09/01/22 Optometri Astigmatism and Pre that can affect your v difficult to see things	11/01/21. In Spectrum Disorder. Ist visit. Diagnoses of esbyopia (two eye conditions vision. Presbyopia makes it close-up, and astigmatism of the conditions and astigmatism of the conditions o					

FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_\_\_ B. WING\_ MHL016-005 04/17/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2331 NORTH LAKEVIEW DRIVE **NEWPORT** NEWPORT, NC 28570 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5)(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) V 291 Continued From page 6 V 291 Interview on 04/17/24 the House Manager stated: - Client #5 had not been to a follow up eye exam since 09/01/22. - The facility usually received a follow up appointment card. - She was aware a system needed to be in place to ensure timely follow up appointments. - She was in the process of setting up a return visit with client #5 for an eye exam.

Division of Health Service Regulation STATE FORM

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If continuation sheet 7 of 7

