STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		
		MHL041-620	B. WING		05/15/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	E, ZIP CODE	
COLTRAN	IE'S GROUP HOME		PON STREET		
		GREENS	SBORO, NC 27407	,	
(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 COMPLETE
V 000	INITIAL COMMENTS		V 000		
	An annual survey was Deficiencies were cite	s completed on 5/15/24. ed.			
	category: 10A NCAC	d for the following service 27G .5600C Supervised Developmental Disabilities.			
		I for 5 and currently has a ey sample consisted of ents.			
V 110	27G .0204 Training/S Paraprofessionals	upervision	V 110		
	SUPERVISION OF PA	ACOMPETENCIES AND ARAPROFESSIONALS privileging requirements for			
	associate professiona professional as specif Subchapter.	ied in Rule .0104 of this			
	population served.	abilities required by the			
	then qualified profess	s established by rulemaking, ionals and associate			
	professionals shall de (e) Competence shall exhibiting core skills in	•			
	(1) technical knowled(2) cultural awarenes(3) analytical skills;	dge;			
	(4) decision-making;(5) interpersonal skil(6) communication s	ls;			
	(7) clinical skills.	dy for each facility shall			

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

(X6) DATE TITLE

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL041-620	B. WING	<u></u>	05/15/2024	
	ROVIDER OR SUPPLIER	3811 RE	DDRESS, CITY, STATI PON STREET BBORO, NC 27407			
(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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE COMPLETE	
V 110	develop and impleme	nt policies and procedures individualized supervision	V 110			
	facility failed to have p supervised by a quali findings are:	iew, and interviews, the				
	- There was not a QP Interview on 5/14/24 v revealed: - A QP had not been over a year.	record. with the Licensee/staff #1 employed by the facility in , she had been the only staff				
V 111	PLAN (a) An assessment so client, according to go the delivery of service be limited to: (1) the client's prese (2) the client's needs	ASSESSMENT AND TATION OR SERVICE hall be completed for a overning body policy, prior to es, and shall include, but not nting problem;	V 111			

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STATE FORM 6899 66ZI11 If continuation sheet 2 of 8

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
		A. BUILDING: _		JOINII LL TED	
		MHL041-620	B. WING		05/15/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
COLTRAN	IE'S GROUP HOME	3811 REPO GREENSB	N STREET ORO, NC 2740	07	
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	BE COMPLETE
TAG	REGULATORY OR I	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	RIATE DATE
V 111	Continued From page	2	V 111		
		determined within 30 days that a client admitted to a			
	detoxification or other shall have an establis	· 24-hour medical program hed diagnosis upon			
	` ' '	l, family, and medical history;			
	and (5) evaluations or as				
	vocational, as approp	e abuse, medical, and riate to the client's needs.			
	establishment and im	=			
	referred to as the "pla	or service plan, hereafter in," strategies to address the			
	client's presenting pro	oblem shall be documented.			
	facility failed to ensure completed prior to the	iew and interviews, the e an assessment was			
	findings are: Review on 5/14/24 of client #3's record revealed: - Admission date: 5/1/22 - Diagnosis: Moderate Intellectual Disability - Admission assessment form was in file but the form was blank.				

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` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	MHL041-620		B. WING	B. WING		
NAME OF PI	ROVIDER OR SUPPLIER	STREET AC	DDRESS, CITY, STATI	E, ZIP CODE		
COLTRAN	E'S GROUP HOME		ON STREET			
			BORO, NC 27407			
(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 CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE	
V 111	Continued From page	3	V 111			
	Review on 5/14/24 of client #4's record revealed: - Admission date: 5/1/22 - Diagnosis: Mild Intellectual Disability - Admission assessment form was in file but the form was blank. Interview on 5/14/24 with the Licensee/staff #1 revealed: - "Probably the QP" would complete the admission assessments for the clients living in the facility A QP had not been employed by the facility in over a year.					
V 112	27G .0205 (C-D) Assessment/Treatme	nt/Habilitation Plan	V 112			
	PLAN (c) The plan shall be assessment, and in p legally responsible per of admission for client receive services beyond (d) The plan shall incomplete the projected date of achieved by provision projected date of achieved (2) strategies; (3) staff responsible; (4) a schedule for reannually in consultation responsible person on (5) basis for evaluation outcome achievement (6) written consent of	developed based on the artnership with the client or erson or both, within 30 days its who are expected to and 30 days. Elude: I that are anticipated to be a of the service and a devement; I wiew of the plan at least on with the client or legally both; on or assessment of t; and ar agreement by the client or				
	responsible party, or	a written statement by the cuent of a written statement by the such consent could not be				

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STATE FORM 6899 66ZI11 If continuation sheet 4 of 8

Division of Fleath Service Regulation		_					
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	A. BUILDING:		COMPLETED	
			D 14/11/0				
		MHL041-620	B. WING		05/15/2024		
NAME OF D	ROVIDER OR SUPPLIER	STDEET AD	DRESS, CITY, STA	ATE ZIR CODE			
NAIVIE OF FI	NOVIDER OR SUFFLIER			ATE, ZIF CODE			
COLTRAN	E'S GROUP HOME		ON STREET				
-		GREENSE	BORO, NC 2740	07			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT	ON (X5)		
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL		ΓE	
TAG	REGULATORY OR L	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO DEFICIENCY)	PRIATE DATE		
				DEFICIENCY)			
V 112	Continued From page	Δ. A	V 112				
•	Continued From page	, -	'				
	obtained.						
	This Rule is not met	as evidenced by:					
	Based on records rev	iew and interviews, the					
	facility staff failed to d	evelop and implement					
		ment/habilitation plan to					
	_	s needs (#1, #3, and #4).					
	The findings are:	7 needs (#1, #5, and #4).					
	rne illidings are.						
	5144104 6						
		client #1's record revealed:					
	- Admission date: 1/1/						
	 Diagnosis: Moderat 	e Intellectual Disability and					
	Epilepsy						
	- There was not an up	odated treatment plan in					
	client #1's record.						
	Review on 5/14/24 of	client #3's record revealed:					
	- Admission date: 5/1/						
		e Intellectual Disability					
	•	odated treatment plan in					
	client #3's record.	odated treatifient plan in					
	CHETTL #3 S TECOTU.						
	D	-1:					
		client #4's record revealed:					
	- Admission date: 5/1/						
	- Diagnosis: Mild Inte						
	- There was not an up	odated treatment plan in					
	client #4's record.	·					
	Interview on 5/14/24 v	with client #1 revealed:					
		e the goals he was working					

on.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		MHL041-620	B. WING		05/15/2024
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	ΓE, ZIP CODE	
COLTRAN	E'S GROUP HOME		PON STREET	7	
040.15	STIMMADA ST	ATEMENT OF DEFICIENCIES	BBORO, NC 2740	PROVIDER'S PLAN OF CORRECTIO	N OVE
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
V 112	Continued From page	e 5	V 112		
	- He could not recall a meeting in the past ye	attending a treatment team ear.			
	Attempted Interview of a Unable to interview	on 5/15/24 with client #3: client.			
		with client #4 revealed: ng able to take care of e care of my brother."			
	revealed: - Normally the QP wo	with the Licensee/staff #1			
	•	ving in the facility, but a QP ed by the facility in over a			
	for client #4 because ago at his day progra treatment plan.	d an updated treatment plan she had a meeting 2 weeks m to update client #4's			
	- "You are going to ha (treatment plans)."	eve to cite me on that			
V 289	27G .5601 Supervise	d Living - Scope	V 289		
	provides residential s	1 SCOPE is a 24-hour facility which ervices to individuals in a here the primary purpose of			
	these services is the rehabilitation of indivi- illness, a developmen	care, habilitation or duals who have a mental ntal disability or disabilities,			
	supervision when in t	g facility shall be licensed if			
	(1) one or more two or more	e minor clients; or e adult clients. es shall not reside in the			

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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	
MHL041-620		B. WING		05/15/2024		
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
COLTRAN	E'S GROUP HOME		ON STREET ORO, NC 2740	17		
(X4) ID		ATEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECTION		
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)		
V 289	Continued From page	e 6	V 289			
	same facility.					
	(c) Each supervised					
	licensed to serve a sp designated below:	becilic population as				
		tion means a facility which				
		primary diagnosis is mental				
	illness but may also h	•				
		tion means a facility which primary diagnosis is a				
		lity but may also have other				
	diagnoses;	, carmay also mare care.				
	(3) "C" designa	tion means a facility which				
		primary diagnosis is a				
	diagnoses;	lity but may also have other				
	` ,	tion means a facility which				
	serves minors whose					
	other diagnoses;	endency but may also have				
		tion means a facility which				
	serves adults whose					
	substance abuse dep	endency but may also have				
	other diagnoses; or					
	` ,	tion means a facility in a				
	•	ich serves no more than ose primary diagnoses is				
	mental illness but ma					
		dult clients or three minor				
	clients whose primary					
		lities but may also have				
		live with a family and the				
		ervice. This facility shall be				
	.0201 (a)(1),(2),(3),(4	wing rules: 10A NCAC 27G				
		; (8); (11); (13); (15); (16);				
		AC 27G .0202(a),(d),(g)(1)				
		203; 10A NCAC 27G .0205				
	(a),(b); 10A NCAC 27	G .0207 (b),(c); 10A NCAC A NCAC 27G .0209[(c)(1) -				

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STATE FORM 6899 66ZI11 If continuation sheet 7 of 8

MMHLO41-620 MMHLO41-620 MMHLO41-620 DENTIFICATION NUMBER A BUILDING DENTIFICATION NUMBER A BUILDING DENTIFICATION NUMBER STREET ADDRESS, CITY, STATE, ZIP CODE 3811 REPON STREET 3814 REPON STREET STREET ADDRESS, CITY, STATE, ZIP CODE 3814 REPON STREET GREENSBORD, NC 27407 PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3814 REPON STREET GREENSBORD, NC 27407 PROVIDER'S PANOF CORRECTION (EACH DEPICIENCY) MUST SE PRECEDED BY PLUL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG CONTINUED From page 7 Non-prescription medications only] (d)(2),(4); (e) (1)(A),(D),(E);(T)(g); and 10 A NCAC 27G .0304 (b)(2),(d)(4). This facility shall also be known as alternative family living or assisted family living (AFL). This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to operate under the scope for which it is licensed. The findings are: Observation at approximately 3:01 pm on 5/15/24 revealed: - The bedroom at the end of the hallway was the Licensee/staff #1 revealed: - Since January 2023, she had been the only staff who worked at the facility, with the clients. - She had a second staff who she could call on in an emergency. Interview on 5/14/24 with staff #2 revealed: - The last time she worked in the facility was a year ago.		OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X			(3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS. CITY. STATE_ ZIP CODE 3811 REPON STREET GREENSBORO, NC. 27407 (44) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES BY FULL PREFIX TAG PROVIDER'S PLAN OF CORRECTION (RCAH OBTRICHENCY MUST BE PRICECED BY FULL PREFIX TAG PROVIDER'S PLAN OF CORRECTION (RCAH OBTRICHENCY MUST BE PRICECED BY FULL TAG PREFIX TAG CROSS-REFERENCY ACTION OF CORRECTION (RCAH OBTRICHENCY MUST BE PRICECED BY FULL TAG PREFIX TAG CROSS-REFERENCY CROSS-REFERENCY COMMETTE DEFICIENCY) V 289 Continued From page 7 V 289 This Rule is not met as evidenced by: Based on observations and interviews, the facility falled to operate under the scope for which it is licensed. The findings are: Observation at approximately 3:01 pm on 5/15/24 revealed: The bedroom at the end of the hallway was the Licensee/staff #1 revealed: Since January 2023, she had been the only staff who worked at the facility. She lived in the facility with the clients. She had a second staff who she could call on in an emergency. Interview on 5/14/24 with staff #2 revealed: The last time she worked in the facility was a	AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETE	ED	
COLTRANE'S GROUP HOME SUMMARY STATEMENT OF DEFICIENCES RECHARDER RECIDENCY MUST BE PRECEDED BY FULL RECULATORY OR LSC IDENTIFYING INFORMATION) V 289 Continued From page 7 non-prescription medications only] (d)(2),(4); (e) (1)(A),(D),(E);(f);(g); and 10A NCAC 27G .0304 (b)(2),(d)(4). This facility shall also be known as alternative family living or assisted family living (AFL). This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to operate under the scope for which it is licensed. The findings are: Observation at approximately 3:01 pm on 5/15/24 revealed: - The bedroom at the end of the hallway was the Licensee/staff #1 revealed: - Since January 2023, she had been the only staff who worked at the facility with the clients. - She had a second staff who she could call on in an emergency. Interview on 5/14/24 with staff #2 revealed: - The last time she worked in the facility was a		MHL041-620		B. WING		05/15/2024		
(A) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDERS PLAN OF CORRECTION (AC) ID PROVIDERS PLAN OF CORRECTION (AC) ID PREFIX (EACH DEFICIENCY MUST BE PRECIDED BY FULL PREFIX TAG (AC) DEFICIENCY MUST BE PRECIDED BY FULL PREFIX TAG (AC) DEFICIENCY MUST BE PRECIDED BY FULL PAGE (AC) DEFICIENCY MUST BE PRECIDED BY FULL PAGE (AC) DEFICIENCY (AC) DEFICIE	NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE			
GREENSBORO, NC 27407 SUMMARY STATEMENT OF DEFICIENCIES Dipart PROVIDERS PLAN OF CORRECTION GEACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR ISC IDENTIFYING INFORMATION) TAG CROSS-REFERENCE TO THE APPROPRIATE DATE V 289 Continued From page 7 Non-prescription medications only] (d)(2),(4); (e) (1)(A),(D),(E);(f);(g); and 10A NCAC 27G .0304 (b)(2),(d)(4). This facility shall also be known as alternative family living or assisted family living (AFL). This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to operate under the scope for which it is licensed. The findings are: Observation at approximately 3:01 pm on 5/15/24 revealed: The bedroom at the end of the hallway was the Licensee/staff #1's bedroom. Interview on 5/14/24 with the Licensee/staff #1 revealed: Since January 2023, she had been the only staff who worked at the facility, with the clients. She had a second staff who she could call on in an emergency. Interview on 5/14/24 with staff #2 revealed: The last time she worked in the facility was a	COLTRAN	IE'S GROUP HOME	3811 REPO	N STREET				
PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) V 289 Continued From page 7 non-prescription medications only] (d)(2),(4); (e) (1)(A),(D),(E),(f);(g); and 10A NCAC 27G .0304 (b)(2),(d)4). This facility shall also be known as alternative family living or assisted family living (AFL). This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to operate under the scope for which it is licensed. The findings are: Observation at approximately 3:01 pm on 5/15/24 revealed: - The bedroom at the end of the hallway was the Licensee/staff #1's bedroom. Interview on 5/14/24 with the Licensee/staff #1 revealed: - Since January 2023, she had been the only staff who worked at the facility with the clients. - She lived in the facility with the clients. - She had a second staff who she could call on in an emergency. Interview on 5/14/24 with staff #2 revealed: - The last time she worked in the facility was a	COLINAI	L 3 GROOF HOME	GREENSB	ORO, NC 2740	07			
non-prescription medications only] (d)(2),(4); (e) (1)(A),(D),(E);(f);(g); and 10A NCAC 27G .0304 (b)(2),(d)(4). This facility shall also be known as alternative family living or assisted family living (AFL). This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to operate under the scope for which it is licensed. The findings are: Observation at approximately 3:01 pm on 5/15/24 revealed: The bedroom at the end of the hallway was the Licensee/staff #1's bedroom. Interview on 5/14/24 with the Licensee/staff #1 revealed: Since January 2023, she had been the only staff who worked at the facility. She lived in the facility with the clients. She had a second staff who she could call on in an emergency. Interview on 5/14/24 with staff #2 revealed: The last time she worked in the facility was a	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI	BE	COMPLETE	
	V 289	non-prescription med (1)(A),(D),(E);(f);(g); a (b)(2),(d)(4). This fact alternative family livin (AFL). This Rule is not met Based on observation failed to operate underlicensed. The finding Observation at approximate revealed: - The bedroom at the Licensee/staff #1's bedroom at the Licensee/s	ications only] (d)(2),(4); (e) and 10A NCAC 27G .0304 cility shall also be known as ag or assisted family living as evidenced by: as and interviews, the facility er the scope for which it is as are: eximately 3:01 pm on 5/15/24 end of the hallway was the edroom. with the Licensee/staff #1 f, she had been the only staff cility. lity with the clients. taff who she could call on in with staff #2 revealed:	V 289				

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