STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING:	(X3) DATE SURVEY COMPLETED		
		MIII 044 077	ALI 044.977 B. WING		00/00/0004
		MHL041-977	B. WING		02/26/2024
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE ENTWOOD STREE		
BRENTW	OOD GROUP HOME		DINT, NC 27263	ı	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	DBE COMPLETE
V 000	INITIAL COMMENTS		V 000		
	2024. Deficiencies we This facility is licensed	d for the following service 27G .5600A Supervised			
	This facility is licensed	d for 6 and currently has a ey sample consisted of			
V 112	PLAN  (c) The plan shall be assessment, and in plegally 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 by a staff responsible;  (3) staff responsible;  (4) a schedule for reannually in consultation responsible person of the person of	developed based on the artnership with the client or erson or both, within 30 days ts who are expected to and 30 days. It was a service and a evement;  view of the plan at least on with the client or legally both; on or assessment of	V 112	received by MHL and C 5-15-24	

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

5/14/24

56BZ11

TITLE

(X6) DATE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	ETED
		MHL041-977	B. WING		02/2	6/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST.	ATE, ZIP CODE		
DDENTW	OOD ODOUD HOME	2325 BRE	NTWOOD STR	EET		
BKENIW	OOD GROUP HOME	HIGH PO	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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
V 112	Continued From page	e 1	V 112	V112		
	facility staff failed to de and strategies in the of 3 audited clients (construction of 3 audited clients) and construction of 3 audited clients of 3 audited clien	ews and interviews, the levelop and implement goals clients' treatment plans for 1 lient #2). The findings are:		QM will facilitate a discussion vesident regarding goals and incorporating a goal regarding Substance Abuse. Thursday the The goal will be incorporate in the by Monday the 27th.	23 <sup>rd</sup> .	5/27/24

Division of Health Service Regulation

Division	of Health Service Regui	auon			_
	T 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
			<u>l</u>		OL/LO/LOL4
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STA		
BRENTW	OOD GROUP HOME	2325 BR	ENTWOOD STRI	EET	
		HIGH PC	INT, NC 27263		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	( - /
PREFIX	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	
TAG	REGOLATORTOR	ESCIDENTIF TING INFORMATION)	TAG	DEFICIENCY)	IAIL SALE
V 112	Continued From page	2	V 112		
	"has an extensive his	tory of mental illness and			
	treatment, presents w	vith previous diagnoses of			
	Schizophrenia and so	ome anxiety, denies any			
	-	symptoms are mostly			
	controlled by Invega i	njections, reports no current			
		cates no current efforts in			
	locating employment	has a history of insomnia			
	and problems with sle	eep, has a history of			
	inpatient hospitalizati	ons with last being in 2014,			
	reports having no sup	ports in place, states he			
	talks with mom spora	dically but has no contact			
	with other family, pres	sents with some insight into			
	symptoms and the us	e of medication in his ability			
	to manage symptoms	s, in March 2016 he was			
	shot with a shotgun th	nat damaged his hip and			
	sciatic nerve in his lef	t leg and was hit in the head			
	with a gun, in Februa	ry 2016 'got a gun charge'			
	per his mother, is diag	gnosed with Alcohol Use			
	Disorder, Moderate, i	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			
		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	_			
		e community so he can			
	-	vised time outside the			
	home."				
	-A treatment plan dat				
	-	dence by maintaining his			
		showering, brushing his			
		clean clothing 7 days per			
		rooming his hair and beard			
	The state of the s	vill increase his independent			
		pating in shared group home			
	sanitation responsibil	•			
		n routing for his bedroom,			
		pendent living skills by			
	participating in at leas	st two (20 minutes) physical			

Division of Health Service Regulation

STATEMEN <sup>*</sup>	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	A. BUILDING:		LETED
			_			
		MHL041-977	B. WING		02/2	26/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE. ZIP CODE	<u> </u>	
			ENTWOOD STRE			
BRENTW	OOD GROUP HOME					
		HIGH PO	INT, 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 SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
V 112	Continued From page	e 3	V 112			
V 112	walking, playing bask park with staff or othe work to decrease the smokes to 7 or less p of cigarettes to discording or strategic diagnosis of Alcohol I consumption of alcohologory of the port, dated 12/15/2 - "Description of Involution (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 Hohim stumbling, slurrint tangential and rambli and difficulty staying not receive Trazadon was told this was due told about the danger - "Strategies Developed Manager contacted pregional nurse. PS acconversation with res RN advised to call ph	cluding but not limited to setball, going to the local er natural supports and will amount of cigarettes he er day limiting the purchase urage increased smoking." es to address client #2's Use Disorder and recent hol.  If the facility's internal incident 3 revealed: Wement: [Client #2] Med in due to resident med error-missed dose. Wement out to the store 'a few in was unusual. When he oticed he seemed ght him into the Manager's me Manager also observed in him into the Manager's me Manager also observed in him into the Manager's me Manager also observed in him into the seemed ght swords, being in speech, glassy eyes standing. As a result, he did not be alcohol consumption and it is of mixing the two."  Bed/Corrective Action Taken: Wed/Corrective Action Taken:	V 112			
	-	l invalid. Group Home				
	Manager called pharma	macy and asked to be cist for advice on whether				
	they did not know, ch	eadministered. They said ecked the manufacturer's Lit should be fine. The Group				

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE	SURVEY LETED	
AND FLAN	OF CORRECTION	IDENTIFICATION NOMBER.	A. BUILDING:		LETED	
		MHL041-977	B. WING		02/	26/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
RRENTW	OOD GROUP HOME	2325 BRE	NTWOOD STRE	ET		
DILLITIV	OOD CROOF FIGURE	HIGH PO	NT, NC 27263			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
V 112	Continued From page	e 4	V 112			
	called RN (Registere RN contacted [Pharm separate pharmacist given for 24 hours aff They advised contact Physician) so a stand future instances."  Review on 2/26/24 of Manager/Qualified Processoription revealed: -"A Position Description signed by the GHM/C Essential Job Function of successes, problem the individuals, their ecommunity and deve	rofessional (GHM/QP)'s job ion, dated 11/14/22 and QP "Group Home Manager: ons:Maintains awareness ms and general attitudes of				
	-"Individual Specific (dated 1/11/24has do it every couple of typically go to the cor He also has a history does this, so keep an leaves the home with Remind [client #2] the right to drink, alcohol to be consumed in pudangers of mixing alcand if he had anythin take the appropriate sidemean or restrict his"	at while he does have the isn't allowed on premises or ablic. Also remind him of the cohol with his medications g, to let us know so we can steps. Do not be judgmental, is choice to consume alcohol with client #2 revealed:				

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STATE FORM 6899 56BZ11 If continuation sheet 5 of 16

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	NITICIONI NILIMPED.	(XZ) WOLTH LL	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN OF CORRECTION IDE	NTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
	ИНL041-977	B. WING		02/26/2024
NAME OF PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE	
BRENTWOOD GROUP HOME	2325 BRI	ENTWOOD STRE	EET	
	HIGH PO	OINT, NC 27263		
(X4) ID SUMMARY STATEMENT PREFIX (EACH DEFICIENCY MUST B TAG REGULATORY OR LSC IDENT	E PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
V 112 Continued From page 5  -"Well, I did drink alcohol wh but not on the premises. The dependents on home much relast time I drank was, let me went 4 months without it (alcoevery once and a while"  -" When I drink I will find a woodswhat I would like to crestaurant's name] and I were I usually drink a couple of be restaurant's name] I get stell myself I do not need a bigoregular sized one I also draw one time and [staff #1] told me apologized to her"  -First started drinking alcoholed -Had previously attended AA Anonymous) meetings  -"The December (2023) incided store. [Staff #1] told me not to anymore to drink it was emigot home. I was dancing and -" I am buying my own alcotolimit my alcohol. I see nothed drinking one or two beers. Nothere"  -" I congratulated myself yewanted to drink alcohol, but it coke I was proud of myself. Interview on 2/23/24 with staff -" I was working the day of client #2] I worked 6am to for Fridayhe left out (of the fact Maybe about 5 something if the and said he was going to the street at the light). He was gower was slurred, he was speech was slurr	amount I drink noney I have. The think, a month ago. I chol). I just drink  spot in the lo is to go to [a at there once to drink eers at [a mall beers I will beer, just a small, nk at the gas station e not to I  in high school (Alcoholics  ent. I was at the go to the store carrassing when I she saw me " whol, and I am trying ing wrong with o one else drinks  esterday because I esterday because I esterday because I esterday because I esterday late afternoon. hat. He signed out store (right down the one for a while. estaggering, his	V 112		

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE	(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING:		COMPLETED
		MHL041-977	B. WING		02/26/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE	
BRENTW	OOD GROUP HOME	2325 BRE	NTWOOD STRE	EET	
		HIGH POI	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 OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	DBE COMPLETE
V 112	act like he was okay. breath. [GHM/QP] wa	I smelled alcohol on his is working that day alsoso has been drinking. He told	V 112		
	took a couple of sips	is friends at the store and and that was it. I knew it 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				
		for [client #2] to get alcohol tore"			
	Interviews on 2/23/24 GHM/QP revealed:				
	plans	nt plans annually and as			
	needed -"I saw [client #2]'s dia that was several year	agnosis of Alcohol Use but s ago"			
	-	eatment team and discuss			
V 290	27G .5602 Supervise	d Living - Staff	V 290		
	of this Rule shall be denable staff to responseeds.  (b) A minimum of one				

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STATE FORM 6899 56BZ11 If continuation sheet 7 of 16

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CO	DNSTRUCTION	(X3) DATE SURVEY COMPLETED	
		MHL041-977	B. WING		02/26/2024
	PROVIDER OR SUPPLIER	2325 BF	ADDRESS, CITY, STATE RENTWOOD STREE DINT, NC 27263		•
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE
V 290	premises, except wh habilitation plan docucapable of remaining without supervision. as needed but not less the client continues to the client continues to the home or communication of the client periods of the communication of the client periods of the communication of the client periods of the child or adolescent of the clients of the clients present for the governing body; the gove	en the client's treatment or uments that the client is in the home or community. The plan shall be reviewed as than annually to ensure to be capable of remaining in nity without supervision for time.  Issent in a facility in the ratios when more than one lient is present:  adolescents with substance and be served with a minimum for every five or fewer minor every, only one staff need be ing hours if specified by the procedures determined by for adolescents with every one to three clients of present for every four or thowever, only one staff ng sleeping hours if regency back-up procedures every four or thowever, only one staff ng sleeping hours if regency back-up procedures every four or thousend the served with every one to three clients of the served with revery one to three clients of the served with revery one to three clients of the served with revery one to three clients of the served with revery one to three clients of the served with reserve the served with revery one to three clients of the served with revery one to three clients of the served with revery one to three clients of the served with revery one to three clients of the served with revery one to three clients of the served with revery one to three clients of the served with revery one to three clients of the served with revery one to three clients of the served with revery one to three clients of the served with revery one to three clients of the served with revery one to three clients of the served with revery one to three clients of the served with revery one to the serve	V 290		

Division of Health Service Regulation

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	T OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONST DE CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONST A. BUILDING:				E SURVEY PLETED	
		MHL041-977	B. WING		02	2/26/2024
	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE,			
BRENTW	OOD GROUP HOME	HIGH PO	DINT, 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 ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
V 290	Continued From page	8	V 290			
	interviews, the facility treatment plans, the cremaining in the home supervision for specific 3 of 3 clients (#1, #2 and Observations on 2/23 of the facility revealed -No answer at the from Observations on 2/23 of the facility revealed -Staff #1 arrived at the -The Group Home Man Professional (GHM/Q) Interview on 2/23/24 of the facility revealed -Staff #1 arrived at the -The Group Home Man Professional (GHM/Q) Interview on 2/23/24 of the facility revealed -Staff #1 arrived at the -The Group Home Man Professional (GHM/Q) Interview on 2/23/24 of the facility revealed -Staff #1 arrived at the -The Group Home Man Professional (GHM/Q) Interview on 2/23/24 of the facility revealed -Staff #1 arrived at the -The Group Home Man Professional (GHM/Q) Interview on 2/23/24 of the facility revealed -Staff #1 arrived at the -The Group Home Man Professional (GHM/Q) Interview on 2/23/24 of the facility revealed -Staff #1 arrived at the -The Group Home Man Professional (GHM/Q) Interview on 2/23/24 of the facility revealed -Staff #1 arrived at the -The Group Home Man Professional (GHM/Q) Interview on 2/23/24 of the facility revealed -Staff #1 arrived at the -The Group Home Man Professional (GHM/Q) Interview on 2/23/24 of the -The Group Home Man Professional (GHM/Q) Interview on 2/23/24 of the -The Group Home Man Professional (GHM/Q) Interview on 2/23/24 of the -The Group Home Man Professional (GHM/Q) Interview on 2/23/24 of the -The Group Home Man Professional (GHM/Q) Interview on 2/23/24 of the -The Group Home Man Professional (GHM/Q) Interview on 2/23/24 of the -The Group Home Man Professional (GHM/Q) Interview on 2/23/24 of the -The Group Home Man Professional (GHM/Q) Interview on 2/23/24 of the -The -The Group Home Man Professional (GHM/Q) Interview on 2/23/24 of the -The -The -The -The -The -The -The -T	as, record reviews and failed to document, in the slients' capability of e or community without led periods of time affecting and #3). The findings are:  //24 from 8:55am to 9:17am di: nt or side doors  //24 from 9:18am to 9:22am di: e facility in the agency's van. anager/Qualified P) arrived at the facility  with the GHM/QP revealed: were inside the facility as				
	-An admission date of -Diagnoses of Attention Disorder (ADHD), Co	on Deficit Hyperactivity mbined, Unspecified um and Other Psychotic				
	-Age 39 -An updated assessm "would like to be more with completing his da 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 idgety at times, as a child he and got into fights, annoyed				

Division of Health Service Regulation

STATE FORM 6899 56BZ11 If continuation sheet 9 of 16

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MI II TIPI F	CONSTRUCTION	(X3) DATE SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	1 1	CONSTRUCTION	COMPLETED
			A. BOILDING		
		MHL041-977	B. WING		02/26/2024
					V2.20.2027
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STA		
BRENTWO	OOD GROUP HOME		ENTWOOD STRI	EE I	
		HIGH PO	INT, NC 27263		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE
V 290	Continued From page	9	V 290		
	burned down when he	e was a child, reports			
		he attic, currently controlled			
	•	rts the voices sounded			
		one, last heard voices 12			
	years ago, his family,	a job and getting his life			
	back on track is impor	rtant to him, multiple			
		ons, has been in group			
		ce 2009, no crisis in the last			
		a head injury at the age of			
		ead on a tree and received			
	•	lack direction in what he			
		life and continues to have g hygiene and independent			
		ased his socialization skills			
	but lacks strong socia				
	-A treatment plan date				
	•	dence and improve his			
	appearance by maint	•			
		brushing his teeth and			
	putting on clean cloth	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,"			
		f client #1's ability to remain			
		unity for specified periods of			
	time in the treatment	*			
	D : 0/00/01	1: 1/101			
		client #2's record revealed:			
	-An admission date of				
		phrenia, Insomnia due to			
		and Tobacco Use Disorder,			
	Moderate -Age 33				
	_	d 8/22/19 noted "currently			
	accessinont date	a s,, is noted building	1		

-An assessment
Division of Health Service Regulation

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	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MI II TIPI E	CONSTRUCTION	(X3) DATE SURVEY	,
	OF CORRECTION	IDENTIFICATION NUMBER:	1 1		COMPLETED	
			A. BUILDING:			
		MHL041-977	B. WING		02/26/202	4
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STA	TE, ZIP CODE		
			ENTWOOD STRI			
BRENTW	OOD GROUP HOME		INT, NC 27263			
			<u> </u>			
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD		(X5) MPLETE
TAG		LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPR		DATE
				DEFICIENCY)		
V 290	Continued From page	2.10	V 290			
V 200	. •		V 200			
	_	chizophrenia, had been				
	· ·	ner for the majority of his life,				
		ger able to physically or				
		n due to her personal health				
		circumstances, needs to be				
		ere he can become more				
		e a healthy life style, needs				
		nsistent with his activities of				
		engage in daily hygiene				
		oing so himself, staff will				
		npt and encourage him to				
		ene regimen and maintain a				
	healthy living environ					
	_	ally keeps to himself, spends				
		video games and listening				
	_	on probation due to a felony				
	charge, has to keep in officer."	n contact with his probation				
	-An updated assessn	nent dated 6/15/23 noted				
	"has an extensive his	tory of mental illness and				
	treatment, presents w	vith previous diagnoses of				
	Schizophrenia and so	ome anxiety, denies any				
	recent psychosis and	symptoms are mostly				
	controlled by Invega i	njections, reports no current				
		cates no current efforts in				
		, has a history of insomnia				
	and problems with sle					
		ons with last being in 2014,				
		pports in place, states he				
		dically but has no contact				
		sents with some insight into				
		se of medication in his ability				
		s, in March 2016 he was				
		nat damaged his hip and				
		ft leg and was hit in the head				
		ry 2016 'got a gun charge'				
		gnosed with Alcohol Use				
		n sustained remission."				
		Insupervised time dated				
	5/4/23 noted "nas spe	ent unsupervised time in the				

DIVISION	of Health Service Regul	ation	•			
STATEMEN	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	URVEY
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	ETED
		MHL041-977	B. WING		02/2	6/2024
NAME OF D	ROVIDER OR SUPPLIER	STDEET AS	DRESS, CITY, STA	TE ZID CODE		
NAME OF P	ROVIDER OR SUPPLIER					
BRENTWOOD GROUP HOME			ENTWOOD STR	EEI		
		HIGH PO	INT, NC 27263			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)
PREFIX	,	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE
TAG	REGULATORY OR I	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR	RIATE	DATE
				DEFICIENCY)		
V 290	Continued From page	e 11	V 290			
	-	safely with no reported				
		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				
		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				
		pating in shared group home				
	sanitation responsibil					
		n routing for his bedroom,				
		pendent living skills by				
	· · · · ·	st two (20 minutes) physical				
		cluding but not limited to				
		etball, going to the local				
	•	r natural supports and will				
		amount of cigarettes he				
		er day limiting the purchase				
	•	urage increased smoking."				
	<ul> <li>No documentation of</li> </ul>	of client #2's ability to remain				
	in the home or comm	unity for specified periods of				
	time in the treatment	plan				
		client #3's record revealed:				
	-An admission date o					
	-Diagnoses of Bipolar	Disorder, Schizophrenia,				
	Hyperlipidemia and H	lypertension				
	-Age 51					
	•	nent dated 12/20/22 noted				
		group home for 25 years,				
		n 12/12/22 'because I got				
		I cut my forearm near the				
		g mess. When I cut my arm,				
		yself.' Medications have				
	i was noping to kill III	your. Inculcations have				

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STATEMENT OF DEFICIENCIES (2		(X1) PROVIDER/SUPPLIER/CLIA	(Y2) MI II TIDI E	CONSTRUCTION	(Y2) DATE SUBVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		A. BUILDING:				
		MHL041-977	B. WING		02/26/202	24
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
		2325 BR	ENTWOOD STR	EET		
BRENTW	OOD GROUP HOME	HIGH PO	DINT, NC 27263			
0(4) ID	CLIMMADV CT	TATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTIO	N.	0(5)
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD		(X5) MPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE	RIATE	DATE
				DEFICIENCY)		
V 290	Continued From page	e 12	V 290			
		ncentrating, continues to				
	have problems falling					
		when he lost his job to				
		ed in 2003 and had a gun				
		sented as paranoid during				
		cooperative, reports his				
		ating and that he cannot				
		ent and insight, needs				
	_	nent, individual and group				
	1 2	d increase social supports,				
	teach coping skills through cognitive behavioral therapy and motivational interviewing, assist with					
		<del>-</del>				
	decreasing depressive symptoms, assist in verbalizing life stressors and help manage					
	delusions."	ors and help manage				
		ed 1/8/24 noted "over the				
	-	mprove his community				
		kercise his unsupervised				
	•	nd participating in at least				
		· · · · · · · · · · · · · · · · · · ·				
	one community activity/event per month, such as (not limited to) church services, sponsored					
	events, movie/music related events or exercise					
		without incident, will use				
		p to research community				
		group home social events				
		courage him to utilize his				
		ervised time in the home				
		ill discuss his outing to				
		incidents or concerns,				
	manager will annually	y update the unsupervised				
		iking adjustments and				
	reviewing as needed,	, over the next 12 months,				
		nunity independence and				
		vised time by picking out and				
	participating in at leas	st one community				
		nth, will improve his physical				
	health and wellness b	by choosing healthy meal				
	operations for self-pre	epared meals as well as				
		cal activity at least three days				
	per week, will increas	se his independent living				

STATEMENT 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 P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
BRENTW	OOD GROUP HOME	2325 BRE	NTWOOD STRE	EET		
DICEITION	OOD GROOT HOME	HIGH POI	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 OF CORRECT (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
V 290	Continued From page	e 13	V 290			
V 290	routine by showering, brushing his -1/11/24 return time listed -No documentation of in the home or commitime in the treatment Review on 2/26/24 of from 12/1/23 to 2/26/2-Client #1 signed in a and times for unsupe community: -2/19/24 departed 10:12pm -2/18/24 departed 10:2:30pm -2/14/24 departed 10:5-2/8/24 departed 10:5-2/8/24 departed 10:5-2/8/24 departed 10:5-2/8/24 departed 10:1-1/31/24 departed 10:1-1/31/24 departed 10:1-1/31/24 departed 10:1-1/5/24 departed 10:1-1/5/24/53 departed 10:1-1/5/5/54 departed 10:1-1/5/5/54 departed 10:1-1/5/5/54 departed 10:1-1/5/5/54 departed 10:1-1/5/5/54 departed 10:1-1/5/5/54 departed 10:1-1/5/54 departed 10:1-1/5/5	is home shared intaining a daily hygiene changing clean clothes and departed 10:40am and no f client #3's ability to remain unity for specified periods of plan the facility's sign in/out log, 24, revealed: nd out on the following dates rvised time in the following dates rvised following dat	V 290			
	11:15am -12/11/23 departed 4:	:10pm and returned 4:30pm				

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STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING:		COMF	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	ENTWOOD STRE	EET			
DICEITION	OOD OROO! HOME	HIGH PO	INT, 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 ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE	
V 290	Continued From page	e 14	V 290				
		5am and returned 10:45am					
	-12/7/23 departed 10:	15am and returned					
	11:30am	0					
		0am and returned 9am 03am and returned 2pm					
	-12/2/23 departed 10.	osam and returned 2pm					
	Review on 2/26/24 of	the facility's sign in/out log,					
	from 12/1/23 to 2/26/2						
	-Client #2 signed in a	nd out on the following dates					
	and times for unsupe	rvised time in the					
	community:						
	-2/21/24 departed 3:	15pm and returned 4pm					
		25pm and returned 6:25pm					
	-	55am and returned 11:20am					
	-2/10/24 departed 3;3						
	-	am and returned 9am					
	-	60am and returned 9:15am					
	-	9pm and returned 8:30pm					
		Oam and returned 9:30am					
	-1/5/24 departed 8:09						
	-12/29/23 departed 10:27am and returned 11:30am						
		:10pm and returned 3:15pm					
		:45am and returned 9:30am					
	-12/15/23 departed 1						
	12:36pm						
	•	35pm and returned 4pm					
		9am and returned 8am					
		0am and returned 9:50					
	-12/5/23 departed 7:5	i1 am and returned 8:30am					
	-12/1/23 departed 10:	30am and returned					
	11:15am						
	•	5am and returned 7:15am					
		9am and returned 9:09am					
	-12/1/23 departed 10:	30am and returned					
	11:15am						
Interviews on 2/23/24 with clients #1, #2 and #3							
	revealed:	·					
		rvised time in the facility and					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED			
AND PLAN	OF CORRECTION	DRRECTION IDENTIFICATION NUMBER: A. BUILDING:			COMPLE	IED		
		MHL041-977	B. WING		02/20	6/2024		
NAME OF P	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
DDENT\//	BRENTWOOD GROUP HOME 2325 BRENTWOOD STREET							
DICEITIV	OOD GROOF HOME	HIGH POIN	T, 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE		
V 290	the community -Were not sure how n time they had in the fa Interview on 2/23/24 v -Clients #1, #2 and #3 both the facility and th -Was not sure how m time the clients had b community -Client #3 did not acc the community "only i  Further interview on 2 revealed: -" I thought all the ti (the treatment plans)	nany hours of unsupervised acility or the community with staff #1 revealed: 3 had unsupervised time in the community than y hours of unsupervised toth in the facility and in the tess his unsupervised time in		Unsupervised Time Assessments revised to include "Community" "Home" as well as indicating the number of approved unsupervised by the GH Manager.  QM will communicate at the new Managers meeting for all to reviresidents Unsupervised Time Assessments and ensure the requirements are met specifically Community and home and separand the hours approved is documents.	and ed hours at GH ew the y, ated out	6/1/24		