Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
				A. BUILDING.		R	
	MHL064-162		B. WING		05/3	0/2024	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
KOODY	HEALTHCARE SERVI	CES INC III	SERTY TRAI IOUNT, NC 2				
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECTION	ON	(X5)	
PREFIX TAG	(EACH DEFICIENC)	/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	COMPLETE DATE	
V 000	INITIAL COMMEN	rs	V 000				
	An annual and follo on 5/30/24. A defici	w up survey was completed ency was cited.					
		sed for the following service C 27G .5600A Supervised th Mental Illness.					
	The facility is licensed for 5 and has a current census of 4. The survey sample consisted of audits of 3 current clients.						
V 290	27G .5602 Supervi	sed Living - Staff	V 290				
	numbers specified of this Rule shall be enable staff to resp needs.  (b) A minimum of opresent at all times premises, except whabilitation plan docapable of remaining without supervision as needed but not letter the client continues the home or commispecified periods of (c) Staff shall be profollowing client-staff child or adolescent (1) children cabuse disorders short one staff present clients present. He present during sleet	os above the minimum in Paragraphs (b), (c) and (d) e determined by the facility to cond to individualized client one staff member shall be when any adult client is on the when the client's treatment or cuments that the client is ng in the home or community. The plan shall be reviewed ess than annually to ensure to be capable of remaining in unity without supervision for fitime.					

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

TITLE (X6) DATE Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED			
7.1.2 / 2.11 0. 00.11.20.10.1			A. BUILDING.		.	R		
MHL064-162			B. WING			30/2024		
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE				
KOODY	KOODY HEALTHCARE SERVICES INC III  781 HAGGERTY TRAIL ROCKY MOUNT, NC 27803							
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	OULD BE COMPLETE			
V 290	Continued From page 1  (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 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 290					
	Based on record reinterviews, the facil was capable of ren community without audited clients (#2)  Review on 5/23/24  - Admitted: 4/17  - Diagnoses: Sc Developmental Dis  - Supervision pla  "moves about community with correquiring staff to be physical proximity of	of Client #2's record revealed: /19 hizoaffective Disorder and order an dated 4/16/22 stated: ut the neighborhood or intinual staff supervision within audible, visual and/or						

Division of Health Service Regulation

STATE FORM 6899 U2JG11 If continuation sheet 2 of 4

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUP IDENTIFICATION		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
							₹
	MHL064-162		B. WING		05/3	30/2024	
NAME OF I	PROVIDER OR SUPPLIER				STATE, ZIP CODE		
KOODY HEALTHCARE SERVICES INC III  781 HAGGERTY TRAIL ROCKY MOUNT, NC 27803							
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	(X5) COMPLETE DATE	
V 290	Continued From pa	ige 2		V 290			
	unsupervised time	assessment					
	Observation on 5/23/24 at approximately 3:50pm revealed: - Client #2 was exiting the public transportation van without facility staff supervision on the van						
	Interview on 5/23/24 Client #2 reported:  - Lived at the facility 6 years  - Attended a day program  - Took public transportation to and from day program  - No facility staff rode public transportation with her, just the van driver						
	Interview on 5/23/24 the Group Home Manager reported:  - Client #2 had unsupervised time  - Did not know if an assessment was completed for Client #2's unsupervised time  - Client #2 attended a day program and utilized public transportation to and from the program  - no staff accompanied Client #2 on public transportation  - the facility's previous Qualified Professional (QP) did the unsupervised time assessments  - the new Qualified Professional had not done an unsupervised time assessment						
	2024 - Did not know s unsupervised time - Did not update assessment becau authorized by a dod - Client #2 was a time when the QP I	d at the facility sin he was responsib assessments Client #2's unsup se she thought it l ctor already utilizing un	ce March ele for ervised time had to be esupervised ty				

Division of Health Service Regulation

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

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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MHL064-162			B. WING		05/3	0/2024
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
KOODY	HEALTHCARE SERVI	CES INC III	GERTY TRAI IOUNT, NC			
(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 SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
V 290	using public transposupervision  Thought the da  Was told last wan unsupervised tincompleted for Client  Interview on 5/30/2:  She had a probeous doing what she was change QP's and transposure assessments was change to the client #2 did had unsupervised time a updated by the old	prtation without staff  y program picked up Client #2 eek by the Administrator that ne assessment needed to be at #2  3 the Administrator reported: elem with the previous QP not a supposed to do and had to nat's how she got the new QP are updated by the new QP ave unsupervised time and the assessment should have been QP at that she needed it for client	V 290			

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