STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
	or connection	IDENTIFICATION NOMBER.	A. BUILDING:				
		MHL034-336	B. WING			R 2 4/2024	
AME OF F	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE			
	ARE SOLUTIONS AT		AND DRIVE RSVILLE, NC 2	27284			
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLET DATE	
V 000	INITIAL COMMEN	rs	V 000				
	An annual, complaint and follow up survey was completed on May 24, 2024. The complaint was substantiated (Intake # NC00217165). Deficiencies were cited.						
	This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disability.						
		sed for 3 and has a current urvey sample consisted of clients.					
V 291	27G .5603 Supervi	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 Coordi maintained betwee qualified profession treatment/habilitation	cility shall serve no more than e clients have mental illness or abilities. Any facility licensed and providing services to more hat time, may continue to no more than the facility's nation. Coordination shall be n the facility operator and the hals who are responsible for on or case management.					
	Responsible Perso provided the oppor relationship with he	the Family or Legally n. Each client shall be tunity to maintain an ongoing er or his family through such the facility and visits outside					
	the facility. Reports annually to the pare legally responsible Reports may be in	s 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					
	progress toward me	eeting individual goals. ties. Each client shall have					

STATE FORM

6899

If continuation sheet 1 of 5

05/24/24

STATEMEN	Division of Health Service Regulation STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING:			
		MHL034-336	B. WING			R 24/2024
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	TATE, ZIP CODE		
НОМЕ С	ARE SOLUTIONS AT					
			SVILLE, NC 2			(1.1-)
(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 C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC)	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
V 291	Continued From pa	age 1	V 291			
	needs and the treat Activities shall be d inclusion. Choices or legal system is in	es based on her/his choices, tment/habilitation plan. lesigned to foster community may be limited when the court nvolved or when health or me a primary concern.				
	Based on record re observation, the fac	et as evidenced by: eview, interviews, and cility failed to coordinate with ffecting 1 of 2 clients (#1). The				
	-Date of Admission -Diagnoses: Intelled Disabilities, Modera unspecified; and Pa -Hospitalization dat -Client #1 was read	ctual Developmental ate; Hyperlipidemia, araphilia, unspecified; ted 5/16/24; dy to be discharged from the . He was not picked up by the				
	the Qualified Profest Program to the Exe -He sent a text mes	of a text message sent from ssional (QP) of the Day ecutive team revealed: ssage dated 5/19/24 to the QP er (RM), the Owner/licensee,				
		4 with client #1 revealed: bital on Friday until Monday."				
	guardian revealed: -Client #1 ran away	/ from the group home on s located on 5/16/24. "The				

Division of Health Service Regulation STATE FORM

6899

If continuation sheet 2 of 5

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION				(X2) MULTIPLE CONSTRUCTION A. BUILDING:		E SURVEY PLETED R
		MHL034-336	B. WING			24/2024
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
OME C	ARE SOLUTIONS AT		AND DRIVE RSVILLE, NC 2	7284		
(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 1 DEFICIENC	THE APPROPRIATE	COMPLE DATE
V 291	Continued From pa	age 2	V 291			
	group home did not pick him (client #1) up until 5/20/24;					
	-I did not understand why [client #1] was left at the hospital that long."					
	Interview on 5/21/2 Program revealed:	4 with the QP of the Day				
	-"I received a call from [nurse] at the hospital at 3:25 pm on 5/19/24."					
	clock, and he did n	unfortunately, he was off the ot provide or arrange				
		would relay the message; he RM was on vacation;				
	-He received a call	from law enforcement on				
	being taken to the	that client #1 was located and hospital.				
		4 with the Qualified for Inland Drive revealed:				
	-"They (licensee) w	ould not leave a member at				
	the hospital especi discharge."	ally when they are ready for				
		a call when [client #1] was e from the hospital or				
	throughout his hos	pitalization;				
		d call the individual whose I to them. The licensee will				
	schedule a time to	pick the member up.				
	Interview on 5/24/2 facility revealed:	4 with the Co-Owner of the				
	-"The facility was s	hort staffed and I asked the				
	The nurse stated, "	client #1) until the next day. 'they are not a babysitting				
		cked up the next day;" e the point of contact with the				
	RM being on vacat	ion;"				
		at client #1 eloped from the [client #1] was in the hospital				

FIPA11

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	MHL034-336		B. WING		R 05/24/2024	
IAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
IOME C	ARE SOLUTIONS AT		ND DRIVE SVILLE, NC 2	7284		
(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 T DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
V 291	the hospital for two attempted to contac of the date;" -"The legal guardia	ge 3 cted me after [client #1] was in days and they (hospital) ct me sooner. He was unsure n (client #1's) texted me to nd I had already made	V 291			
V 736	10A NCAC 27G .03 EXTERIOR REQUI (c) Each facility and maintained in a saf manner and shall b odor. This Rule is not me Based on observati failed to ensure the be maintained in a	l its grounds shall be e, clean, attractive and orderly e kept free from offensive	V 736			
	Observation on 5/2 of the facility reveal -The oven had burr -The shower surrou with black stains; -A mattress and bo Interview on 5/24/2 -"I don't go in the ba -He was unaware of	nt food particles in the bottom; and and tub was discolored x spring was in the back yard. 4 with staff #1 revealed:				
		4 with staff #2 revealed: P of the Day Program or the				

FIPA11

		(X1) PROVIDER/SUPPLIER/CLIA		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		ECTION IDENTIFICATION NUMBER:		A. BUILDING:			
		MHL034-336	B. WING			R 24/2024	
AME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE			
	ARE SOLUTIONS AT		ND DRIVE				
		KERNER:	SVILLE, NC 2	7284			
(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 ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC [\]	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
V 736	Continued From pa	age 4	V 736				
	RM about maintenance needs at the facility.						
	-"I am responsible Inland;" -He and the RM ar staff appropriately -He had big items	24 with the Co-Owner revealed: for maintenance needs at re responsible to make sure clean the facility; at the facility picked up by city en he would haul the items					

FIPA11