STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL091-118	A. BUILDING: _____ B. WING _____	R-C 06/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VANCE ADULT GROUP HOME	941 HWY 158 BY PASS HENDERSON, NC 27536

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 000	INITIAL COMMENTS A complaint and follow up survey was completed on June 14, 2024. The complaint was unsubstantiated (intake #NC00217406). A deficiency was cited. This facility is licensed for the following service: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disability. This facility is licensed for 5 and has a current census of 5. The survey sample consisted of audits of 3 current clients.	V 000		
V 291	27G .5603 Supervised Living - Operations 10A NCAC 27G .5603 OPERATIONS (a) Capacity. A facility shall serve no more than six clients when the clients have mental illness or developmental disabilities. Any facility licensed on June 15, 2001, and providing services to more than six clients at that time, may continue to provide services at no more than the facility's licensed capacity. (b) Service Coordination. Coordination shall be maintained between the facility operator and the qualified professionals who are responsible for treatment/habilitation or case management. (c) Participation of the Family or Legally 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	V 291		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL091-118	A. BUILDING: _____ B. WING _____	R-C 06/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VANCE ADULT GROUP HOME	941 HWY 158 BY PASS HENDERSON, NC 27536

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 291	Continued From page 1 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 observation, record review and interview the facility failed to coordinate with other qualified professionals who are responsible for 1 of 5 current client's (#1) treatment. The findings are: Review on 6/13/24 & 6/14/24 of client #1's record revealed: - admitted 3/1/10 - diagnoses: Moderate Intellectual Development Disorder, Congestive Heart Failure, Obesity, Sleep Apnea - a physician's order dated 10/6/22: Obstructive Sleep Apnea on Continuous Positive Airway Pressure (CPAP) Observation on 6/13/24 at 4:46pm & 4:51pm revealed the following: - 4:46pm: a CPAP machine on client#1's nightstand - 4:51pm: client #1 showed a new CPAP machine in a box without the hose During interview on 6/13/24 client #1 reported: - the CPAP machine sometimes cut off when she cuts it on - happened about twice a month - told the previous Group Home Manager (GHM)	V 291		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL091-118	A. BUILDING: _____ B. WING _____	R-C 06/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VANCE ADULT GROUP HOME	941 HWY 158 BY PASS HENDERSON, NC 27536

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 291	Continued From page 2 - not sure why a new CPAP machine was sent without the hose During interview on 6/13/24 staff #1 reported: - client #1 received a new CPAP machine in August 2023 or Sept 2023 - the hose did not come with the new CPAP machine - she and the current GHM had reached out to the CPAP company - the CPAP representative informed them to reach out to the manufacturer company - she did not document the attempts to the CPAP company During interview on 6/13/24 the current GHM reported: - thought client #1 received the new CPAP machine around August 2023 - thought the new CPAP machine was received due to a recall on the old CPAP machine - was not aware the CPAP machine would cut off when client #1 cut it on - had contacted the CPAP company regarding the hose to the new CPAP machine - did not document the attempts - would reach out to the CPAP company tomorrow for further details regarding the hose for the new CPAP machine During interview on 6/14/24 the Qualified Professional (QP) reported: - was not aware of any issues with client #1's CPAP machine until this interview - as the QP of the facility, would like to know any concerns regarding the clients	V 291		