	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
	MHL049-074	B. WING			10/07/2024	
ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE			
IER ROAD			ROAD			
					(ME)	
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
INITIAL COMMENTS		V 000				
An annual survey was deficiency was cited.	s completed on 10/7/24. A					
category: 10A NCAC	27G .5600C Supervised					
census of 3. The surv	ey sample consisted of					
27G .5602 Supervise	d Living - Staff	V 290				
<ul> <li>(a) Staff-client ratios numbers specified in of this Rule shall be of enable staff to respon- needs.</li> <li>(b) A minimum of one present at all times w premises, except whe habilitation plan docu capable of remaining without supervision.</li> <li>as needed but not less the client continues to the home or commun- specified periods of ti (c) Staff shall be present following client-staff ri- child or adolescent cl (1) children or a abuse disorders shall of one staff present for clients present. How</li> </ul>	above the minimum Paragraphs (b), (c) and (d) letermined by the facility to ad to individualized client e staff member shall be hen any adult client is on the en the client's treatment or ments that the client is in the home or community The plan shall be reviewed as than annually to ensure be capable of remaining in ity without supervision for me. sent in a facility in the atios when more than one ient is present: adolescents with substance be served with a minimum or every five or fewer minor vever, only one staff need be					
	OF DEFICIENCIES OF CORRECTION ROVIDER OR SUPPLIER SUMMARY ST. (EACH DEFICIENC REGULATORY OR I INITIAL COMMENTS An annual survey was deficiency was cited. This facility is license category: 10A NCAC Living for Adults with This facility is license census of 3. The surv audits of 3 current clice 27G .5602 Supervise 10A NCAC 27G .5602 (a) Staff-client ratios numbers specified in of this Rule shall be con enable staff to resport needs. (b) A minimum of one present at all times w premises, except whe habilitation plan docu capable of remaining without supervision. as needed but not less the client continues to the home or commun specified periods of ti (c) Staff shall be present following client-staff r child or adolescent cl (1) children or a abuse disorders shall of one staff present for clients present. How	IDENTIFICATION NUMBER:         MHL049-074         ROVIDER OR SUPPLIER       STREET A         IER ROAD       335 NOF         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       INITIAL COMMENTS         An annual survey was completed on 10/7/24. A deficiency was cited.       A         This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disability.         This facility is licensed for 3 and has a current census of 3. The survey sample consisted of audits of 3 current clients.         27G .5602 Supervised Living - Staff         10A NCAC 27G .5602 STAFF         (a) Staff-client ratios above the minimum numbers specified in Paragraphs (b), (c) and (d) of this Rule shall be determined by the facility to enable staff to respond to individualized client needs.         (b) A minimum of one staff member shall be present at all times when any adult client is on the premises, except when the client's treatment or habilitation plan documents that the client is capable of remaining in the home or community without supervision. The plan shall be reviewed as needed but not less than annually to ensure the client continues to be capable of remaining in the home or community without supervision for specified periods of time.         (c) Staff shall be present in a facility in the following client-staff ratios when more than one child or adolescent client is present:	OF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLA       (X2) MULTIPLE CL         IP CORRECTION       INHL049-074       B. WING         MHL049-074       B. WING	OF DEFICIENCIES       (X1) PROVIDERSUPPLERCUA       (X2) MULTIPLE CONSTRUCTION         IF CORRECTION       MHL049-074       B. WING         MIL049-074         STREET ADDRESS, CITY, STATE, ZIP CODE         ABLIDING:         MIL049-074         BER ROAD         STREET ADDRESS, CITY, STATE, ZIP CODE         IER ROAD         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REQUINTRY OR USCIDENTIFYING INFORMATION)         REGULATORY OR USCIDENTIFYING INFORMATION)       PREFIX (EACH OORRECTIVE AN CROSS-REFERENCED TO (EACH OORRECTIVE AN CROSS-REFERENCED TO CROSS-REFERENCED TO (EACH OORRECTIVE AN CROSS-REFERENCED TO CROSS-REFERENCED TO CROSS-REFERENCED TO (EACH OORRECTIVE AN CROSS-REFERENCED TO CROSS-REFERENCED TO CROSS-REFERENCED TO (EACH OORES AN THE AND CROSS-REFERENCED TO CROSS-REF	or DEPICIENCIES FCORRECTION     (X1) PROVIDERSUPPLIERCULA IDENTIFICATION NUMBER:     (X2) MULTIPLE CONSTRUCTION A BUILDING:     (X2) MULTIPLE CONSTRUCTION A BUILDING:     (X2) DATA A BUILDING:       MILDA9-074     B. WING     10       NOVDER OR SUPPLIER     STREET ADDRESS, CITY, STATE, ZIP CODE       IER ROAD     335 NORTH GREENBRIER ROAD STATESVILLE, NO 26625       SUMMARY STATEMENT OF DEPICIENCIES RECORDER PROVIDERS PROVIDERS PLAN OF CORRECTION IECAH ODEFICIENCY MUST BE PRECEDED DY FULL REGULATORY OR LISC IDENTIFYING INFORMATION)     ID PROVIDERS PLAN OF CORRECTION CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY MUST BE PRECEDED OF VILL REGULATORY OR LISC IDENTIFYING INFORMATION)     PROVIDERS PLAN OF CORRECTION CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY MUST BE PRECEDED OF VILL REGULATORY OR LISC IDENTIFYING INFORMATION)     PROVIDERS PLAN OF CORRECTION CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY       INITIAL COMMENTS     V 000     V 000     An annual survey was completed on 10/7/24. A deficiency was as cited.     V 000       This facility is licensed for the following service category: 10A NCAC 27G. 5500C SUPERVISED Living for Adults with Developmental Disability.     V 290       10A NCAC 27G. 5502 STAFF (a) Staff-client ratios above the minimum numbers specified in Paragraphs (b), (c) and (d) of this Rule shall be determined by the facility to enable of remaining in the home or community without supervision. The plan shall be reviewed as needed but not less than annually to ensure the client on tiles then annually to ensure the client on tiles then annually to ensure the client on tiles then annually to ensure the client on telses than annually to ensure the client on telsesthan annually to	

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AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	CATION NUMBER: A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL049-074	B. WING		10	0/07/2024
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE, 2			
GREENB	RIER ROAD		RTH GREENBRIER R VILLE, NC 28625	CAD		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLET DATE
V 290	<ul> <li>Continued From page 1</li> <li>(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.</li> <li>(d) In facilities which serve clients whose primary diagnosis is substance abuse dependency:</li> <li>(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</li> <li>(2) the services of a certified substance abuse counselor shall be available on an as-needed basis for each client.</li> </ul>		V 290			
	facility failed to ensur	as evidenced by: and record reviews, the re staffing to meet the of the clients served. The				
	<ul> <li>Admission Date: 3/4</li> <li>Diagnoses: Severe Major Depression wit Disorder (D/O); Hydr placement; Bilateral I Nystagmus: Esotropi</li> <li>A treatment plan da</li> <li>"needs assistance</li> </ul>	Intellectual Disabilities; th Psychotic Feature; Seizure ocephalus with shunt Mature Cataracts; a; and Congenital Blindless				

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If continuation sheet 2 of 4

AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ICATION NUMBER: A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		MHL049-074			10/07/2024		
NAME OF PI	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE			
GREENBF	RIER ROAD			ROAD			
			VILLE, NC 28625				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TO THE APPROPRIATE DA		
V 290	Continued From pag	e 2	V 290				
	must assist [client #1						
	what going on and to	etting by informing him of step up/downstairs or					
	-	nonitored when he's outside being in the sunneeds					
		ers with his self-help skills, /iping buttock area from BM					
	(bowel movement, g	ait, balance, meal prep,					
[Clie incre com hims (day		walking, getting in/out of vehicles, dressing, etc [Client #1's] level of assistance from other has					
	increased, he will ask for help because he's not						
	comfortable of doing things by himself or for himselfNeeds Residential Supports III 7 D/w						
	(days a week) to meet his needs at the residential						
		one to one supports he elp skills, daily living skills					
	and a structure routin						
		f Client #3's record revealed:					
-D Bij De D/ -A su	- Admission Date: 1/ -Diagnoses: Modera	15/2007 ate Intellectual Disabilities;					
	Bipolar D/O; Impulse	Control D/O; Attention					
	, ,, ,	D/O ; Generalized Anxiety nd Traumatic Brain Injury					
	-A treatment plan da	ted 5/1/24 included "I need					
		e my activities of daily living. I e sure that grooming,					
	bathing, and persona	al hygiene has been					
		Make sure of proper cleaning ementI need extensive					
	U	n of aggressive behavior."					
		ne FL2 Form" signed by client					
	#3's medical doctor o "Requires 24 hour su	upervision for health and					
	safety."						
	Interview on 10/7/24						
	Supervisor revealed:	t shift worked 8 am-4pm;					
sion of Her	alth Service Regulation						

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STATEMENT OF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA         AND PLAN OF CORRECTION       IDENTIFICATION NUMBER:         MHL049-074					(X3) DATE SURVEY COMPLETED	
		B. WING		10/07/2024		
AME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	ZIP CODE		
REENBI	RIER ROAD		RTH GREENBRIER   VILLE, NC 28625	ROAD		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE
V 290	Continued From pag	le 3	V 290			
	worked 11 pm- 8 am - Two staff worked 12 2nd and 3rd shift dur - During the weeken each shift. - Client #3 did not reduring the week on t #3 did not receive or shift on the weekend Interview on 10/7/24 - Two staff worked 12 2nd and 3rd shift dur - During the weekend each shift. Interview on 10/7/24 Professional reveale - Client #3 does not 1 - Client #1 had a one shift. - On the weekend or shift.	st shift and One staff worked ring the week. d one staff member worked ceive one-on-one services he 2nd and 3rd shift. Client ne on one services during any ls. with staff #1 revealed: st shift and One staff worked ring the week. d one staff member worked with the Qualified d:				

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