Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		MHL0411249	B. WING		01/07/2025	
NAME OF PROVIDER OR SUPPLIER STREET ADD			DDRESS, CITY, STA	TE ZIP CODE		
			NCY STREET	,		
VANGUARD HOME GREENSBORO, NC 27401						
(X4) ID	(X4) ID SUMMARY STATEMENT OF DEFICIENCIES			PROVIDER'S PLAN OF CORRECTIO	N (X5)	
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)		
V 000	INITIAL COMMENTS		V 000			
		as completed on January 7, was substantiated (intake ficiency was cited.				
	This facility is licensed for the following service category: 10A NCAC 27G .5600B Supervised Living for Minor with Developmental Disabilities.					
		d for 3 and has a current ey sample consisted of ent.				
V 291	27G .5603 Supervised	d Living - Operations	V 291			
	six clients when the codevelopmental disabilition on June 15, 2001, and than six clients at that provide services at no licensed capacity. (b) Service Coordinal maintained between the qualified professionals treatment/habilitation (c) Participation of the Responsible Person. provided the opportunal relationship with her comeans as visits to the the facility. Reports annually to the parent legally responsible per Reports may be in work conference and shall progress toward meeting that is a six client of the conference and shall progress toward meeting that is a six client of the conference and shall progress toward meeting that is a six client of the conference and shall progress toward meeting that is a six client of the conference and shall progress toward meeting that is a six client of the conference and shall progress toward meeting that is a six client of the conference and shall progress toward meeting that is a six client of the conference and shall progress toward meeting that is a six client of the conference and shall progress toward meeting that is a six client of the conference and shall progress toward meeting that is a six client of the conference and shall progress toward meeting that is a six client of the conference and shall progress toward meeting that is a six client of the conference and shall progress toward meeting that is a six client of the conference and shall progress to the conference and shall progress toward meeting that is a six client of the conference and shall progress to the conference and the c	ty shall serve no more than lients have mental illness or lities. Any facility licensed d providing services to more at time, may continue to more than the facility's ation. Coordination shall be the facility operator and the swho are responsible for or case management. The Family or Legally Each client shall be not into the facility and visits outside thall be submitted at least at of a minor resident, or the terson of an adult resident. Iting or take the form of a focus on the client's ting individual goals.				
	(d) Program Activities	s. Each client shall have pased on her/his choices,				

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED		
		MHL0411249	B. WING		01	/07/2025
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	ZIP CODE		
		1601 QU	INCY STREET			
VANGUA	RD HOME	GREENS	BORO, NC 27401			
(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 ACT CROSS-REFERENCED TO DEFICIENCE)	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
V 291	inclusion. Choices m	ent/habilitation plan. signed to foster community ay be limited when the court olved or when health or	V 291			
	Qualified Professiona	as evidenced by: ews and interviews, the Il (QP) failed to coordinate Id clients (#1). The findings				
	-An admission date of -Diagnoses of Severe Autism, Oppositional Deficit Hyperactivity I Behavior -Age 17 -An assessment date history of being hospi behavior, needs supp destructive behaviors directions, can be dis anger control and car weight and size (6'5", (may not understand do), will throw objects you, maternal grandn present in his life but many natural support needs residential place the community, to att therapy and was prevent in the sidential Treatment.	e Intellectual Disability, Defiant Disorder, Attention				

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Division of	<u>of Health Service Regu</u>	ılation				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:			COMPLE	ETED
			-			
			B. WING			
		MHL0411249	B. WING		01/0	7/2025
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	ATE, ZIP CODE		
			NCY STREET			
VANGUAF	RD HOME		BORO, NC 274	04		
			DURU, NC 2/4	T		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPI		DATE
		,	,,,,,	DEFICIENCY)		
V 291	Continued From page	e 2	V 291			
	-An undated treatmer	nt plan dated 4/9/24 noted				
		d anger management skills				
	when upset by not de					
		, , , ,				
		aggressive with others with				
		al prompts (vps), will exhibit				
		home and community by not				
	talking to strangers, r					
	0	both ways before crossing				
		prompt, will increase his age				
		lls by interacting with others				
		ting personal boundaries,				
		s, no speaking excessively)				
		a variety of social activities in				
	the community and at	t home with 4 vps, will				
	appropriately learn ho	ow to communicate his want				
	and needs in an effect	ctive manner with no more				
	than 2 vps, will exhibi	it compliance by getting				
	ready for scheduled e	events/activities in a timely				
	•	than 3 vps, with no more				
		lete a chore at least 3 times				
		y basis, will complete his				
		no more than 3 vps from				
	staff."					
	Further review on 1/6	3/25 of client #1's record				
	revealed:	, 20 of cheffe in 1 o record				
		r dated 10/14/22 noted "				
		of [client #1] is granted to				
		;], that [mother's name] shall				
		upervised visitation for a				
	minimum of four hour					
	overnight visitation ev	very other weekend"				
	1.1	20 12 1 1/4				
		rith client #1 revealed:				
	-Was at his mother's	nome.				
	-Was safe.					
	-Was taking his medic	cations as prescribed.				
	Review on 1/7/25 of t	he overnight receipt for				

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client #1's medications revealed:

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
MIII 0444040		B. WING		24/27/2227		
MHL0411249					01/07/2025	
NAME OF PI	ROVIDER OR SUPPLIER		DRESS, CITY, STA NCY STREET	TE, ZIP CODE		
VANGUAF	RD HOME		BORO, NC 2740	01		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
V 291	Continued From page	e 3	V 291			
	-Was dated 12/16/24 -The medications were address and not the Landers and instead the grandmother whoe-"The biggest issue was requested client #1's address and instead mother's address." Interview on 1/7/25 was revealed:	re sent to the mother's LG's address. ith client #1's care on as the facility was nt people, the mother and was the legal guardian. was the legal guardian medications be sent to her they were sent to the ith the Legal Guardian (LG)				
	12/1/24) with his moth -The mother failed to on 12/1/24 -On 12/2/24, learned mother. -No one contacted he #1 had not returned to -Had requested client overnighted to her ad -"Instead, the medica daughter's house. Sh	client #1 to the facility client #1 was still with his er on 12/1/24 to state client to the facility a #1's medications be dress. tions were sent to my e is not the Legal Guardian,				
	my address like I required Interview on 1/6/25 where Professional #1 (QP and a -Was the QP for the function of the fact. Interview on 1/6/25 where	ith the Qualified #1) revealed: acility nat had transpired until after ith the Director revealed: sion for the mother to pick				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X A. BUILDING:			X3) DATE SURVEY COMPLETED	
		MHL0411249	B. WING		01	/07/2025
NAME OF P	ROVIDER OR SUPPLIER	STREET A	E, ZIP CODE			
VANGUA	RD HOME		IINCY STREET SBORO, NC 27401			
(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 C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
V 291	-The mother was to r -The mother failed to facilityHad contacted the L #1 was still with his n to the facilityThe LG had request overnighted to her ac -The medications we mother's address"I sent the medication because that was wh -QP #1 was responsi facility"The communication daughter was between	eturn client #1 on 12/1/24. return client #1 to the G on 12/2/24 to state client nother and had not returned ed medications be lidress. re overnighted to the ans to the mother's address ere [client #1] was." ble for the oversight of the with the LG and her en me, staff #1 and staff #2." e future, the QP was involved	V 291			

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