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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED			
AND FLAN	OF CORRECTION	IDENTIFICATION NOMBER.	A. BUILDING:		COMPLETED			
		MHL088-021	B. WING		12/31/2024			
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE				
FISHER R	FISHER ROAD GROUP HOME 120 FISHER ROAD							
		BREVARD	, NC 28712					
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLE			
V 000	INITIAL COMMENTS		V 000					
	An annual survey was 31, 2024. Deficiencie	s completed on December s were cited.						
	This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities.							
		d for 3 and currently has a vey sample consisted of ents.						
V 108	27G .0202 (F-I) Perso	onnel Requirements	V 108					
	10A NCAC 27G .0202 PERSONNEL REQUIREMENTS (f) Continuing education shall be documented. (g) Employee training programs shall be							
	provided and, at a minimum, shall consist of the following:							
	` '	tional orientation; rights and confidentiality as AC 27C, 27D, 27E, 27F and						
		he mh/dd/sa needs of the he treatment/habilitation						
	(4) training in infection bloodborne pathogen	S.						
	.5602(b) of this Subcl member shall be avail	ed under 10a NCAC 27G napter, at least one staff lable in the facility at all						
	times when a client is member shall be train including seizure mar							
	to provide cardiopulm	nonary resuscitation and h maneuver or other first aid						
		n maneuver or other lirst aid nose provided by Red Cross,						
	the American Heart A equivalence for reliev	ssociation or their ing airway obstruction.						

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

TITLE (X6) DATE Division of Health Service Regulation

DIVISION	i Health Service Negu	lation	1			
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COMPLETED	1	
			D MANAGE			
		MHL088-021	B. WING		12/31/20)24
NAME OF D	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE ZIR CODE		
NAME OF T	TOVIDER OR SOLT LIER			TE, ZII GODE		
FISHER R	OAD GROUP HOME	120 FISHE				
		BREVARD	, NC 28712			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PRÉFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		OMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR	IATE	DATE
				DEFICIENCY)		
V 108	Continued From none		V 108			
V 106	Continued From page	9 1	V 106			
	(i) The governing boo	dv shall develop and				
		d procedures for identifying,				
		g and controlling infectious				
		seases of personnel and				
	clients.					
	This Rule is not met	as evidenced by:				
		<u> </u>				
	Based on record review and interview, the facility failed to ensure 1 of 3 audited staff (Residential					
	- <i>'</i>	first aid/cardiopulmonary				
	resuscitation (CPR) tr	aining. The findings are:				
	Review on 12/31/24 c	of the Residential Manager's				
	employee record reve	ealed:				
	-date of hire 9/26/18.					
	-First aid/CPR training	n expired 12/8/24				
		y exp.:.ea : =/e/= ::				
	Interview on 12/30/24	with the Pesidential				
		with the Desiderillar				
	Manager revealed:	toff we ample ou Many Herri				
	•	taff member Monday -				
	Friday, 3:00 p.m. to 1					
		6:00 a.m. when she got the				
	clients up to get ready	y to attend the day program.				
	Interview on 12/31/24	with the Program Director				
	revealed:	-				
	-there was an "electro	onic system that was				
		when a staff member was				
	due for trainings.	mon a stan monibol was				
		12/5/24 and the Besidential				
		12/5/24 and the Residential				
	Manager was not on t					
	-	n "missed her (Residential				
	Manager)."					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			7. Bolebino.				
		MHL088-021	B. WING		12/31/2024		
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE			
FISHER ROAD GROUP HOME 120 FISHER ROAD							
TISTILIKIK	OAD GROOF HOME	BREVARI), NC 28712				
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V 290	Continued From page	2	V 290				
V 290	27G .5602 Supervise	d Living - Staff	V 290				
	Continued From page 2 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: (1) children or adolescents with substance abuse disorders shall be served with a minimum of one staff present for every five or fewer minor 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; or (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:						

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STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING:		COMPLETE	D
		MHL088-021	B. WING		12/31/2	024
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
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		BREVARD	, NC 28712			
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V 290	Continued From page	e 3	V 290			
	duty shall be trained i withdrawal symptoms secondary complicati drug addiction; and	in alcohol and other drug s and symptoms of ons to alcohol and other s of a certified substance Il be available on an				
	failed to update 1 of 3 treatment plan to incl remaining in the facili specified periods of til Review on 12/30/24 or revealed: -date of admission 3/-diagnoses of Modera Developmental Disab Schizoaffective Disor Disorder, Unspecified Hypertension and Hy-3/11/24 - form entitle #2] Unsupervised Tin demonstrated that sh Road Group Home wup to two hours per o-2/8/24 - most recent	and record review, the facility of clients (Client #2) ude the capability of ty without supervision for time. The findings are: of Client #2's record 12/09. ate Intellectual continuity, Unspecified der, Unspecified Anxiety of Bipolar Disorder, perlipidemia. ad"Stay Alone Plan for [Client time[Client #2] has e may stay alone at Fisher continuity in the continuity of the continuity.				
	-she was able to stay	with Client #2 revealed: at the facility by herself 2 at she got to do this "every				

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	OF DEFICIENCIES DF CORRECTION	, ,		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		
		MHL088-021	B. WING		12	/31/2024
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA	ΓE, ZIP CODE		
FISHER R	OAD GROUP HOME	120 FISHI BREVARI	ER ROAD D, NC 28712			
(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 (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
V 290	Continued From page	÷ 4	V 290			
	up to 2 hoursif she did not want to she could stay home -this did not occur ever participate about 50% -she attended the day Interview on 12/31/24 Coordinator/Qualified -Client #2 was approvunsupervised up to 2 -parameters were set to take a shower while	participate during outings unsupervised. ery day, she "chooses not to of the days." y program every week day. with the Residential Professional revealed: yed to stay at the facility hours a day. , for example, she was not e staff were gone, and was wave, not the stove/oven. if #2's treatment plan vised time and the they "can certainly				

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