Division of Health Service Regulation (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: B. WING 02/05/2025 MHL0601409 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2537 ARDEN GATE LANE RICE HOME CHARLOTTE, NC 28262 (X5) COMPLETE PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) V 000 V 000 INITIAL COMMENTS An annual survey was completed on 2/5/25. A deficiency was cited. This facility is licensed for the following service category: 10A NCAC 27G .5600F Supervised DHSR-MH Licensure Sect Living for Alternative Family Living. This facility is licensed for 3 and has a current census of 2. The survey sample consisted of audits of 2 clients. V 289 V 289 27G .5601 Supervised Living - Scope SCOPE 10A NCAC 27G .5601 (a) Supervised living is a 24-hour facility which provides residential services to individuals in a home environment where the primary purpose of these services is the care, habilitation or rehabilitation of individuals who have a mental illness, a developmental disability or disabilities, or a substance abuse disorder, and who require supervision when in the residence. (b) A supervised living facility shall be licensed if the facility serves either: one or more minor clients; or (1)two or more adult clients. (2)Minor and adult clients shall not reside in the same facility. (c) Each supervised living facility shall be licensed to serve a specific population as designated below: "A" designation means a facility which serves adults whose primary diagnosis is mental illness but may also have other diagnoses; "B" designation means a facility which serves minors whose primary diagnosis is a developmental disability but may also have other diagnoses: "C" designation means a facility which (3)Division of Health Service Regulation

LABORATORY DIRECTOR'S OR PROVIDER SUPPLIER REPRESENTATIVE'S SIGNATURE

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Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING MHL0601409 02/05/2025 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2537 ARDEN GATE LANE RICE HOME CHARLOTTE, NC 28262 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION **PREFIX** (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) V 289 Continued From page 1 V 289 serves adults whose primary diagnosis is a developmental disability but may also have other diagnoses; (4)"D" designation means a facility which serves minors whose primary diagnosis is substance abuse dependency but may also have other diagnoses: "E" designation means a facility which serves adults whose primary diagnosis is substance abuse dependency but may also have other diagnoses; or "F" designation means a facility in a private residence, which serves no more than three adult clients whose primary diagnoses is mental illness but may also have other disabilities, or three adult clients or three minor clients whose primary diagnoses is developmental disabilities but may also have other disabilities who live with a family and the family provides the service. This facility shall be exempt from the following rules: 10A NCAC 27G .0201 (a)(1),(2),(3),(4),(5)(A)&(B); (6); (7) (A),(B),(E),(F),(G),(H); (8); (11); (13); (15); (16); (18) and (b); 10A NCAC 27G .0202(a),(d),(g)(1) (i); 10A NCAC 27G .0203; 10A NCAC 27G .0205 (a),(b); 10A NCAC 27G .0207 (b),(c); 10A NCAC 27G .0208 (b),(e); 10A NCAC 27G .0209[(c)(1) non-prescription medications only] (d)(2),(4); (e) (1)(A),(D),(E);(f);(g); and 10A NCAC 27G .0304 (b)(2),(d)(4). This facility shall also be known as alternative family living or assisted family living (AFL). This Rule is not met as evidenced by: Based on record review and interviews, the

Division of Health Service Regulation			(Y2) MULTIPLE (	CONSTRUCTION	(X3) DATE SURVEY	
STATEMENT OF DEFICIENCIES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA	A. BUILDING:		COMPLETED	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BOILDING.		1		
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STREET ADDRESS, CITY, STATE, ZIP CODE						
NAME OF PROVIDER OR SUPPLIER  2537 ARDEN GATE LANE						
RICE HOME CHARLOTTE, NC 28262						
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	O THE APPROPRIATE DATE	
V 289	Continued From page 2		V 289			
, 200	facility failed to operate under the scope for which it is licensed. This affected one of one client (#2). The findings are:					
	Review on 2/4/25 of facility's license revealed:  - The program code and description: 10A NCAC 27G .5600F Supervised Living for Alternative Family Living  Review on 2/4/25 of client #2's record revealed:  - Admission date: 5/8/23  - Diagnoses: Major Depressive Disorder, Single Episode, Unspecified; Cerebral Palsy; Severe Intellectual Disabilities; Anorexia; Gastrostomy Status; Constipation, Unspecified; Unspecified Hearing Loss, Unspecified Ear; Disturbances of Salivary Secretion; Dysphagia, Unspecified; Adult Failure to Thrive; Hyperosmolality; Hypernatremia; Unspecified Otitis Externa, Unspecified ear; Unspecified Perforation of Tympanic Membrane, Unspecified Ear; Acute Sinusitis, Unspecified; Abrasion, Unspecified Lower Leg, Initial Encounter; Shortness of Breath; Quadriplegia; and Vitamin D Deficiency  - He did not have residential goals in his treatment plan.			RECEIVED		
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				Brisk-Mil Licensure Se	ect	
	- He was unable to Interview on 2/5/2 Living (AFL) Provo-Typically, client: Thursday. Then come on Friday and the provided resemble of the community living	ew on 2/4/25 with client #2: to answer questions.  25 with the Alternative Family rider #1 revealed: #2 lived at the facility Monday-client #2 went to his mother's and stayed with her until Monday rpite services as well as and support to client #2. ide residential services to client	/.			

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Division of Health Service Regulation **FORM APPROVED** STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING: \_\_ COMPLETED MHL0601409 B. WING 02/05/2025 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2537 ARDEN GATE LANE RICE HOME CHARLOTTE, NC 28262 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETE DATE PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) V 289 Continued From page 3 V 289 Interviews on 2/4/25 and 2/5/25 with the Qualified Professional #2 revealed: - Client #2 lived in the facility "4-5 nights" per week. - Client #2 received 84 hours a week of community living and support. - The AFL Provider #1 provided respite services to client #2 in the facility. - Client #2 did not receive residential services.

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