

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL013-209	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 03/27/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER A PLACE OF MY OWN, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 315 LOWER POND ROAD KANNAPOLIS, NC 28083
---	--

(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	<p>INITIAL COMMENTS</p> <p>An annual and follow up survey was completed on 3/27/25. Deficiencies were cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .5600B Supervised Living for Minors with Developmental Disability.</p> <p>This facility is licensed for 3 and has a current census of 2. The survey sample consisted of audits of 2 current clients.</p>	V 000		
V 112	<p>27G .0205 (C-D) Assessment/Treatment/Habilitation Plan</p> <p>10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN</p> <p>(c) The plan shall be developed based on the assessment, and in partnership with the client or legally responsible person or both, within 30 days of admission for clients who are expected to receive services beyond 30 days.</p> <p>(d) The plan shall include:</p> <p>(1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement;</p> <p>(2) strategies;</p> <p>(3) staff responsible;</p> <p>(4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both;</p> <p>(5) basis for evaluation or assessment of outcome achievement; and</p> <p>(6) written consent or agreement by the client or responsible party, or a written statement by the provider stating why such consent could not be obtained.</p>	V 112		

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL013-209	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 03/27/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER A PLACE OF MY OWN, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 315 LOWER POND ROAD KANNAPOLIS, NC 28083
---	--

(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 112	<p>Continued From page 1</p> <p>This Rule is not met as evidenced by: Based on record review and interview the facility failed to review the treatment plan annually with written consent or agreement by the client's legal guardian or responsible party affecting 2 of 2 audited clients (#1 and #2). The findings are:</p> <p>Review on 3/26/25 of client #1's record revealed: -Admission date of 8/7/23. -Diagnoses of Intellectual Developmental Disability, Attention-Deficit Hyperactivity Disorder, and Autism. -Short term goals were last updated 8/7/23. -There was not a signature or written consent from the guardian or responsible party on client #1's short term goals.</p> <p>Review on 3/26/25 of client #2's record revealed: -Admission date of 11/7/23. -Diagnoses of Autism Spectrum Disorder, intellectual Impairment and Language Impairment, Moderate Intellectual Disability. -Short term goals were last updated 11/7/23. -There was not a signature or written consent from the guardian or responsible party on client #2's short term goals.</p> <p>Interview on 3/26/25 with the Owner/Qualified Professional revealed: -At the annual "ISP (Individual Support Plan) meeting the care manager develops the long term goals, then we develop the short term</p>	V 112		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL013-209	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 03/27/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER A PLACE OF MY OWN, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 315 LOWER POND ROAD KANNAPOLIS, NC 28083
---	--

(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 112	Continued From page 2 goals." -Did not update short term goals until the goals were achieved at 90%. -Clients #1 and #2 had not achieved their goals at 90% and therefore they had not been updated. -"We do not get a physical signature (from the guardian) because we are all part of the planning." Interview on 3/26/25 with the Owner #2 revealed: -"Guardians don't sign the short term goals." -"They (guardians) sign the ISP." -"There has never been a signature required for the short term goals."	V 112		
V 752	27G .0304(b)(4) Hot Water Temperatures 10A NCAC 27G .0304 FACILITY DESIGN AND EQUIPMENT (b) Safety: Each facility shall be designed, constructed and equipped in a manner that ensures the physical safety of clients, staff and visitors. (4) In areas of the facility where clients are exposed to hot water, the temperature of the water shall be maintained between 100-116 degrees Fahrenheit. This Rule is not met as evidenced by: Based on observation and interview, the facility failed to maintain water temperature between 100-116 degrees Fahrenheit where clients are exposed to hot water. The findings are: Observation on 3/26/25 of the facility at approximately 3:30pm revealed: -Water temperature in the kitchen sink and upstairs bathroom sink and shower was 118	V 752		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL013-209	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 03/27/2025
--	---	---	--

NAME OF PROVIDER OR SUPPLIER A PLACE OF MY OWN, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 315 LOWER POND ROAD KANNAPOLIS, NC 28083
---	--

(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 752	<p>Continued From page 3</p> <p>degrees Fahrenheit.</p> <p>-Water temperature in the downstairs bathroom sink was 120 degrees Fahrenheit.</p> <p>Attempted interview with client #1 on 3/26/25 was unsuccessful since he was nonverbal.</p> <p>Attempted interview with client #2 on 3/26/25 was unsuccessful because he answered yes to all questions.</p> <p>Interview on 3/26/25 with staff #1 revealed:</p> <p>-Adjusted the water for clients #1 and #2.</p> <p>-There had not been any injuries due to hot water.</p> <p>-"When the fire department came out they told us (facility staff) it was high and we lowered it.</p> <p>-"We (facility staff) will lower it again."</p> <p>Interview on 3/26/25 with the Program Manager/Qualified Professional (QP) revealed:</p> <p>-Was not aware the water was too hot.</p> <p>-The water heater had recently been replaced.</p> <p>-Staff adjusted the water for the clients.</p> <p>-There had not been any injuries due to hot water.</p> <p>-Would lower the water temperature.</p>	V 752		