PRINTED: 03/31/2025 FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
					F	₹	
		MHL096-078	B. WING		03/2	6/2025	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
PINEVIEW 304 SOUTH PINEVIEW AVENUE GOLDSBORO, NC 27530							
(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 SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	CTIVE ACTION SHOULD BE ICED TO THE APPROPRIATE		
V 000	V 000 INITIAL COMMENTS		V 000				
	on March 26, 2025. This facility is licens category: 10A NCA Living for Adults wit This facility is licens census of 6. The s						
V 290	census of 6. 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: (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		V 290				

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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:				(3) DATE SURVEY COMPLETED	
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		MHL096-078	B. WING		03/2	6/2025	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
PINEVIE	w		H PINEVIEW DRO, NC 27				
(V4) ID	SLIMMA DV STA			PROVIDER'S PLAN OF CORRECTION	ON.	(VE)	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ULD BE COMPLETE		
V 290	Continued From page 1		V 290				
	(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: (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 (2) the services of a certified substance abuse counselor shall be available on an as-needed basis for each client.						
	failed to ensure 1 of treatment plan door remaining in the compectified periods of the series of the	view and interview the facility f 3 audited clients (#6) umented they were capable of mmunity unsupervised for times. The findings are: 5 and 03/26/25 of client #6's 0. umatic Brain Injury and					

Division of Health Service Regulation STATE FORM

TE FORM IGWP11 If continuation sheet 2 of 3

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BUILDING.		R	
		MHL096-078	B. WING			6/2025
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
PINEVIE	w		H PINEVIEW			
(X4) ID	SUMMARY STA		DRO, NC 27	PROVIDER'S PLAN OF CORRECTION	ON.	(X5)
PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	N SHOULD BE COMPLETE	
V 290	Continued From page 2		V 290			
V 290	Interview on 03/26/. - He was his own g - He was able to wa unsupervised for 30 Interview on 03/26/. - She worked at the - Client #6 had 30 r - Client #6 was able without staff superv Interview on 03/25/. - Client #6 had unsupervised to the community. - The facility had as unsupervised time The most recent I time in the plan for	25 client #6 stated: uardian. alk in the community) minutes a day. 25 staff #6 stated: e facility for 4 years. minutes of unsupervised time. e to walk in the neighborhood vision. 25 the House Manager stated: upervised time. alk around the neighborhood 25 the Qualified Professional upervised time in the essessed client #6 for SP did not have unsupervised client #6. ecified time client #6 was	V 290			

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