(FAX)910 642 4085

P.002/006

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	(X3) DATE SURVEY COMPLETED						
	MHL024-109		B. WING	R 03/20/2025					
NAME OF F	PROVIDER OR SUPPLIER		DORESS, CITY, ST	FATE, ZIP CODE	•				
COLUMBUS HOUSE 220 EAST COLUMBUS STREET WHITEVILLE, NC 28472									
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES		ID PREFIX	TON (X5) JLD BE COMPLETE						
PREFIX TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPR DEFICIENCY)					
V 000	INITIAL COMMENTS		V 000		,				
		ow up survey was completed Deficiencies were cited.			,				
	10A NCAC 27G .5	sed for the following category: 300C Supervised Living for pmental Disabilities.							
		sed for 5 and currently has a survey sample consisted of clients.							
V 121	27G .0209 (F) Med	dication Requirements	V 121						
	governing body or for obtaining a review shall be to be perfusive. The onthe client's physicithe review when m (2) The findings of be recorded in the corrective action, i	ew: eives psychotropic drugs, the operator shall be responsible iew of each client's drug very six months. The review ormed by a pharmacist or site manager shall assure that an is informed of the results of nedical intervention is indicated the drug regimen review shall client record along with f applicable.	1						
	Based on record r facility failed to ob of 3 clients (#2, ar psychotropic medi	net as evidenced by: eviews and interviews the tain drug regimen reviews for 2 id #3) who received ications. The findings are:							
Yiriniaa af L	<u> </u>	of client #2 record revealed:		· · · · · · · · · · · · · · · · · · ·					
LIVISION OF F LABORATOR	lealth Service Regulation Y DIRECTOR'S OR PRQ¥	n Ider/şuppher representative's si	GNATURE	TITLE	(X6) DATE				

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. (X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED					
		MHL024-109	B, WING		03/2	0/2025				
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE										
COLUMBUS HOUSE 220 EAST COLUMBUS STREET WHITEVILLE, NC 28472										
(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)	LD BE	(X5) COMPLETE DATE				
V 121	-Admission date of -Diagnoses of Auticanoses of Aut	stic Disorder and Severe IDD Regimen reviews were of client #2's physician order the following psychotropic reat psychotic disorders) seizures) seizures) of client #3's record revealed: of 11/01/15. wn Syndrome and Moderate Regimen reviews were of client #3's physician order the following psychotropic otoms of Parkinson's disease) seizures)	V 121	The QP will ensure the completion of required drug regime for residents of psychotropic medications. The PM (Program/House Manager) ensure verification of drug reviews accordingly within the client record, The PM will complete this task thro implementation of a filing system will documentation provided by the QP filed, will be filed weekly. The QP will conduct random client reviews to ensure required docume found within the client chart as required monthly.	will are filed , timely. ugh the where all to be chart intation is	4/19/2025				

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(X3) DATE SURVEY

(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: _ B. WING 03/20/2025 MHL024-109 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 220 EAST COLUMBUS STREET **COLUMBUS HOUSE** WHITEVILLE, NC 28472 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) V 121 V 121 Continued From page 2 Interview on 3/20/25 the Executive Director stated: -Drug Regimen reviews were completed by the pharmacist in December. -The Home Manager needs to be better organized and file those in the client records. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days. V 291 V 291 27G .5603 Supervised Living - Operations The PM will ensure the coordination of 4/19/2025 services for all residents and that all items ordered are available at all times. This 10A NCAC 27G .5603 **OPERATIONS** includes items determined to be medically (a) Capacity. A facility shall serve no more than six clients when the clients have mental illness or necessary such a as Ensure. developmental disabilities. Any facility licensed on June 15, 2001, and providing services to more Should there be a billing issues, the PM will than six clients at that time, may continue to immediately notify the QP. The QP will provide services at no more than the facility's explore the billing issues and ensure they licensed capacity. are resolved timely. (b) Service Coordination. Coordination shall be maintained between the facility operator and the At no time will items determined to be qualified professionals who are responsible for medically necessary are not obtained, treatment/habilitation or case management. regardless of billing concerns, and will be (c) Participation of the Family or Legally available for residents as ordered. Responsible Person. Each client shall be provided the opportunity to maintain an ongoing relationship with her or his family through such means as visits to the facility and visits outside the facility. Reports shall be submitted at least annually to the parent of a minor resident, or the legally responsible person of an adult resident. Reports may be in writing or take the form of a conference and shall focus on the client's progress toward meeting individual goals. (d) Program Activities. Each client shall have activity opportunities based on her/his choices, needs and the treatment/habilitation plan.

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(X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: ____ B. WING 03/20/2025 MHL024-109 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 220 EAST COLUMBUS STREET **COLUMBUS HOUSE** WHITEVILLE, NC 28472 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) 1D COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) V 291 V 291 Continued From page 3 Activities shall be designed to foster community inclusion. Choices may be limited when the court or legal system is involved or when health or safety issues become a primary concern. This Rule is not met as evidenced by: Based on record review and interview the facility failed to coordinate services for one of three clients (#3). The findings are: Review on 3/19/25 of client #3's record revealed: - Admission date of 11/01/15. - Diagnoses of Down Syndrome and Moderate IDD Review on 3/19/25 of client #3's physician order dated 9/19/24 revealed: -Ensure- PRN (as needed) three times a day if 50 percent of her meals are not completed. Review on 3/19/25 of client #3's medications revealed no Ensure present. Interview on 3/19/25 the Home Manager stated: -Client #3 had been out of Ensure for about 2 weeks. -Client #1's medicaid would not pay for the Ensure Clear and she was having to pay out of pocket. -Was referred by the pharmacy to the Department of Aging to buy the Ensure at a lower cost but it was thirty five dollars for a small case. -Had not informed management of this issue with the Ensure. Interview on 3/19/25 the Qualified Professional stated:

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Division of Health Service Regulation (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A, BUILDING: _____ B. WING 03/20/2025 MHL024-109 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 220 EAST COLUMBUS STREET **COLUMBUS HOUSE** WHITEVILLE, NC 28472 (X5) COMPLETE DATE PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) V 291 V 291 Continued From page 4 -Was not aware that client #3's medicaid was not paying for the the Ensure. -Would reach out to the care coordinator to see if she could add the Ensure to her waiver services to pay for it. -Not aware client #3 had been out of Ensure for the last two weeks. Interview on 3/20/25 the Executive Director stated: -Not acceptable that client #3 was out of Ensure and having to pay for it out of her pocket. -No one had mentioned this was an issue, but will be addressed immediately.