STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DATE SURVEY COMPLETED	
7415 1 2741	or coractorion	BEITH 10/11/6/THOMBET	A. BUILDING:	<u></u>			
		MHL064-095	B. WING		04/1	6/2025	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	ODRESS, CITY, S	STATE, ZIP CODE			
STEVE A	VENT		NSET AVENU MOUNT, NC 2				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
V 000	INITIAL COMMEN	ΓS	V 000				
	An annual survey w Deficiencies were o	/as completed on 4/16/25. cited.					
		sed for the following service C 27G .5600F Supervised e Family Living.					
		sed for 3 and has a current urvey sample consisted of clients.					
V 108	27G .0202 (F-I) Per	rsonnel Requirements	V 108				
	(g) Employee train provided and, at a refollowing: (1) general organiz (2) training on clier delineated in 10A N 10A NCAC 26B; (3) training to mee client as specified in plan; and (4) training in infect bloodborne pathogon (h) Except as permus. 5602(b) of this Submember shall be an times when a client member shall be traincluding seizure must to provide cardioput trained in the Heim techniques such as	cation shall be documented. ing programs shall be minimum, shall consist of the zational orientation; nt rights and confidentiality as ICAC 27C, 27D, 27E, 27F and t the mh/dd/sa needs of the n the treatment/habilitation tious diseases and					

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				DATE SURVEY COMPLETED	
		MHL064-095	B. WING		04/1	6/2025	
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
STEVE A	VENT		SET AVENU OUNT, NC 2				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE	
V 108	(i) The governing be implement policies reporting, investigar	ge 1 body shall develop and and procedures for identifying, ting and controlling infectious diseases of personnel and	V 108				
	to ensure 1 of 2 statraining in first aid/c (CPR). The findings Review on 4/16/25 record revealed:	view and interview the facility ff (Licensee) had current cardiopulmonary resuscitation					
	During interview on Professional report - she sent emails Living (AFL) provide - first aid/CPR was last month - the Licensee w she was not sure w - would notify the aid/CPR trainings	4/14/25 the Qualified ed: s to all Alternative Family ers regarding trainings as offered to AFL providers as sent and email, however thy he did not attend e Licensee of upcoming first					
	reported: - the QP notified aid/CPR training - does not alway.	4/14/25 the Licensee him he missed the first s look at his emails t to see if there were any CPR training					

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	OT HEAITH SERVICE RE	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	` '		COMPLETED	
		MHL064-095	B. WING		04/1	6/2025
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
STEVE A	VENT		SET AVENU OUNT, NC			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROL DEFICIENCY)	D BE	(X5) COMPLETE DATE
V 118	Continued From page 2		V 118			
V 118	27G .0209 (C) Medication Requirements		V 118			
	. •					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED			
	7 L BOILBING.					
MHL064-095	B. WING		04/1	6/2025		
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3925 SUNSET AVENUE						
STEVE AVENT	OUNT, NC 2					
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE		
This Rule is not met as evidenced by: Based on record review and interview the facility failed to administer a medication on the written order of a physician for 1 of 2 clients (#2). The findings are: Review on 4/16/25 of client #2's record revealed: - admitted 12/28/10 - diagnoses: Mild Intellectual Developmental Disorder and Schizophrenia - a physician's consultation dated 2/18/25: decrease from .5 milligrams (mg) to .25 mg (anxiety) Observation on 4/16/25 at 1:02pm of client #2's medications revealed: - Clonazepam .5mg as needed Review on 4/16/25 of client #2's March 2025 and April 2025 MARs revealed: - Clonazepam was transcribed as .5mg as needed - staff documented as administered nightly During interview on 4/16/25 the Licensee reported: - he transported client #2 to the physician's office - client #2's physician continuously changed the Clonazepam - he would follow up with the physician	V 118					

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