Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL036-404	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/06/2025

NAME OF PROVIDER OR SUPPLIER LEO'S DEVOTION	STREET ADDRESS, CITY, STATE, ZIP CODE **1559 PLANTATION TRAIL** **GASTONIA, NC 28056**

(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	**INITIAL COMMENTS** An annual survey was completed on 08/06/2025. A deficiency was cited. This facility is licensed for the following service category: 10A NCAC 27G .5600F Supervised Living for Alternative Family Living. This facility is licensed for 2 and has a current census of 1. The survey sample consisted of audits of 1 current client.	V 000		
V 108	**27G .0202 (F-I) Personnel Requirements** 10A NCAC 27G .0202 PERSONNEL REQUIREMENTS (f) Continuing education shall be documented. (g) Employee training programs shall be provided and, at a minimum, shall consist of the following: (1) general organizational orientation; (2) training on client rights and confidentiality as delineated in 10A NCAC 27C, 27D, 27E, 27F and 10A NCAC 26B; (3) training to meet the mh/dd/sa needs of the client as specified in the treatment/habilitation plan; and (4) training in infectious diseases and bloodborne pathogens. (h) Except as permitted under 10a NCAC 27G .5602(b) of this Subchapter, at least one staff member shall be available in the facility at all times when a client is present. That staff member shall be trained in basic first aid including seizure management, currently trained to provide cardiopulmonary resuscitation and trained in the Heimlich maneuver or other first aid techniques such as those provided by Red Cross, the American Heart Association or their equivalence for relieving airway obstruction.	V 108		

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:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____	(X3) DATE SURVEY COMPLETED
	MHL036-404	B. WING _____	**08/06/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEO'S DEVOTION	**1559 PLANTATION TRAIL** **GASTONIA, NC 28056**

(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 108	Continued From page 1 (i) The governing body shall develop and implement policies and procedures for identifying, reporting, investigating and controlling infectious and communicable diseases of personnel and clients. This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to ensure 1 of 2 audited Staff (#1) had current Cardiopulmonary Resuscitation (CPR)/First Aid (FA) training. The findings are: Review on 08/06/2025 of Staff #1's personnel record revealed: - Date of hire: 11/30/2024. -CPR/FA training expired 08/27/2024. - No documentation of current CPR/FA training. Interview on 08/05/2025 with Staff #1 revealed: -CPR/FA training was up to date. Interview on 08/06/2025 with the Qualified Professional revealed: -"I remember her (Staff #1) saying she had to go to training (CPR/FA) about 2 months ago. I don't know if they (Administrative Assistant) forgot to put the training in her record or not." Interview on 08/06/2025 with the Administrative Director revealed: -"I do a 3-month audit and for the individuals that need CPR/FA, we schedule, and I don't see how I missed that (Staff #1's expired CPR/FA training)." -"So, that one (Staff #1's expired CPR/FA training) is on me."	V 108		

Division of Health Service Regulation

STATE FORM

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL036-404	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEO'S DEVOTION	1559 PLANTATION TRAIL GASTONIA, NC 28056

(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 108	Continued From page 2 -"... but I will double check and continue to look more closely and save the files when they come to me."	V 108		

Division of Health Service Regulation

STATE FORM