		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		MHL026-857	B. WING		R 11/27/2018
	PROVIDER OR SUPPLIER	711 MID	DDRESS, CITY, S DLE ROAD EVILLE, NC 2	STATE, ZIP CODE	1
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AU DEFICIENCY)	HOULD BE COMPLET
V 000	INITIAL COMMEN	TS	V 000		
		w-up survey was completed 2018. Deficiencies were cited.		RECEIVED By DHSR - Mental Health Lic. & Cert. Section	at 8:14 am, Dec 14, 2018
		sed for the following service C 27G .5600A Supervised th Mental Illness.	2 K D	21 21 2 H	e , e ,
V 112	27G .0205 (C-D) Assessment/Treatr	nent/Habilitation Plan	<u>V112</u>		
	PLAN (c) The plan shall assessment, and ir legally responsible of admission for cli receive services be (d) The plan shall (1) client outcome		to specif from hav elopeme and mor	er #4's PCP will be reviewe ically address strategies to ving further elopements. T ents, staff will be trained on hitored for implementation he Manager and QP on a w	prevent the client o prevent further n the revision n by
	projected date of a (2) strategies; (3) staff responsib (4) a schedule for annually in consulta responsible person (5) basis for evalua outcome achievem (6) written consent responsible party, o	chievement; le; review of the plan at least ation with the client or legally or both; ation or assessment of			
	obtained.				
		DER/SUPPLIER REPRESENTATIVE'S SIG			

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		E SURVEY
		NUL 000 057	B. WING		2.2555734	R
		MHL026-857		1	111/	27/2018
AME OF F	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE		
LITE CA	ARE SERVICES AT M	IDDIERD	VILLE, NC 2	28302		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLE DATE
V 112	Continued From pa	age 1	V 112			
	Based on record re facility failed to dev	et as evidenced by: eviews and interviews, the elop and implement strategies ent affecting one of three b. The findings are:				
	 - 31 year old male. - Admission date of - Diagnoses of Sch 	3 of client #4's record revealed: f 02/28/17. izophrenia, Autism Spectrum s Use Disorder and Alcohol				
	revealed: - "How Best To Sup when he talks about assist him in resolv expresses." - "Strategies for cris- stabilizationIf [Clief	Profile (PCP) dates 03/01/18 oportRedirect [Client #4] it eloping from the facility and ing the concerns that he sis response and ent #4] elopes, walk with him				
	staff's support and hours, call 911 to re - The PCP did not i strategies to addres	return. If he refused to accept is away from the facility for 3 sport him missing." nclude any specific goals or ss client #4's continued a day program or group home.				¢.
	report for client #4 of - He eloped from th	of a level I facility incident dated 11/20/18 revealed: e day program. a local department store and				
	revealed: - 11/07/18 - Client #	of facility communication logs device the second second second second second second second second second second second second second second second se				

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STATEMENT OF DEI AND PLAN OF CORF		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL026-857	a construction of a second structure of the second s	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED R 11/27/2018
NAME OF PROVIDER	R OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE	
ELITE CARE SE	RVICES AT M	noi e po	DLE ROAD EVILLE, NC 2	28302	
	ACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE
- 11/08 was re Intervie - He hi approx - He so clients - He w eloped Intervie - He ha years. - Client called. - The he their ag Intervie - He ha years. - Client called. - The he years. - He pr - Client - He ha years. - He pr - Client - He ha years. - The p - Client - He ha years. - The p - Client - He ha years. - He pr - Client - He ha years. - He pr - Client - He ha years. - He pr - Client - The ha years. - He pr - Client - The p - Client - The ha years. - He pr - Client - The p	turned by the ew on 11/26/ ad resided at simately 1 yea ometimes felt and would w as not able to from the fac ew on 11/26/ ad worked at t #4 had a his t #4 walked o olice were invits can leave f ocal police se gency as soo ew on 11/26/1 ad worked at ovided 1:1 fo : #4 walked o ast two walk o d police involu- olice would b or 3 hours. police said the to the facility s	44 eloped from the facility and a local police department. 18 client #4 stated: the group home for ar. excluded from the other alk off from the group home. o state any specific dates he ility. 18 staff #1 stated: the facility for approximately 3 story of walking away from the ff about 2 weeks ago and the volved. for 3 hours and then police are eemed to request contact to n as client #4 walked off. 8 staff #2 stated: the facility for approximately 3 r client #4 at times. ff from the facility at times. offs related to client #4			
stated: - Client	#4 had walk	8 the Qualified Professional ed off from the facility. PCP needed to include			4

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If continuation sheet 3 of 16

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Division	of Health Service R	egulation		1	i oran	in the tes
STATEMEN	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ALCONTROLLING AND ALCONTROL	CONSTRUCTION		E SURVEY PLETED
AND PLAN	OF CONTECTION		A. BUILDING:			R
		MHL026-857	B. WING		1 S. C. T. S. S. C. T. S. S. C. T. S. S. S. C. T. S. S. C. T. S.	27/2018
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE	1	
ELITE C	ARE SERVICES AT M	IDDI E RD	LE ROAD			
		FATETIE	VILLE, NC 28	and the second se		100000
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETE DATE
V 112	Continued From pa	ige 3	V 112			
	current and ongoin address client #4's	g goals and strategies to elopements.	8		ł	
	This deficiency con and must be correct	stitutes a recited deficiency ted within 30 days.		¹ 124 ⁴ V ⁴⁸ ⁶ X		
			<u>V114</u>			с л
V 114	27G .0207 Emerge	ncy Plans and Supplies				+
	10A NCAC 27G .02 AND SUPPLIES	207 EMERGENCY PLANS	Corrective	Action	1	3
	(a) A written fire pla	n for each facility and plan shall be developed and	It is the Po	olicy of Elite Care Service	es to conduct	t Fire and
<i>p</i>		by the appropriate local		orills once a month on ea		
	authority.			tation of the drills will be		
		e made available to all staff cedures and routes shall be		y will be kept at the faci		
	posted in the facility			on of the drills will be mo		
	shall be held at least	st quarterly and shall be		on a monthly basis and i		
y		shift. Drills shall be conducted at simulate fire emergencies.	quarterly	가장의 사람들과 가지면 이 편이에 걸렸다. 그는 것이 같아요. 이 것이다.		1
		all have basic first aid supplies				
	accessible for use.		10 () 10			
					an dani se so	· · · · · · · · · · · ·
					6	
	This Rule is not me					
	Based on record re	view and interviews the facility nd disaster drills held at least	- A - A			
		ited on each shift. The		X 1		
	findings are:		- " Énc	1.00	1.1	
	Review on 11/27/18 revealed:	of facility records for 2018	ta da la			
	- No documented fi	re or disaster drills from				
	January 2018 thru - No 3rd shift fire or	June 2018. disaster drills from July 2018		T,		
	thru September 20		3		1	

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STATEMEN	of Health Service R NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL026-857	(X2) MULTIPI A. BUILDING B. WING	E CONSTRUCTION		(X3) DATE S COMPLI R 11/27	URVEY ETED
NAME OF	PROVIDER OR SUPPLIER	San and a star many strategies and a star strategie	DRESS, CITY,	STATE, ZIP CODE	1		
ELITE C	ARE SERVICES AT M		ULE ROAD	28302			4
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLA (EACH CORRECTIVE CROSS-REFERENCED DEFIC	ACTION SHOU	ILD BE	(X5) COMPLETE DATE
V 114	Continued From pa	age 4	V 114	0			
	they had participate the facility.	18 client #1, #3 and #4 stated ed in fire and disaster drills at				1	
2	stated: - 1st shift - 8am-4p - 2nd shift - 4pm-12 - 3rd shift - 12 midr	2 midnight.	41-21-5 - 21-5 -			4	
V 118	disaster drills from No additional docu to end of survey.	January 2018 thru June 2018. mentation was received prior	<u>V118</u>				
	10A NCAC 27G .02 REQUIREMENTS (c) Medication adm	209 MEDICATION	<u>Correctiv</u>	e Action		3	21 85 MB
	(1) Prescription or i only be administere order of a person a drugs.	non-prescription drugs shall ed to a client on the written uthorized by law to prescribe all be self-administered by	going for the consu	ber 27 th , 2018, Elite ward all medication mer's chart to acco	s will have mpany pr	a physici escribed n	ans' order in nedications as
	clients only when a client's physician. (3) Medications, ind administered only b	uthorized in writing by the cluding injections, shall be by licensed persons, or by trained by a registered nurse,	Documen and Admi	Il staff will be train tation, and MAR Re nistering medicatio	econciliation n will be n	on. MAR's	, Documentatio
	pharmacist or other privileged to prepar (4) A Medication Ac all drugs administer current. Medication	r legally qualified person and e and administer medications. Iministration Record (MAR) of red to each client must be kept s administered shall be ely after administration. The					

Division of Health Service Regulation STATE FORM

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If continuation sheet 5 of 16

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	of Health Service F IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:		. 1		LETED
		MHL026-857 B. WING				F 11/2	7/2018
IAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, STA	TE, ZÍP CODE	1		
LITE C/	ARE SERVICES AT M	Alinni e pn	DLE ROAD EVILLE, NC 283	02			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE CROSS-REFERENCED DEFIC	ACTION SHOU	LD BE	(X5) COMPLET DATE
V 118	Continued From p	age 5	V 118	a nation			
	 (C) instructions for (D) date and time (E) name or initials drug. (5) Client requests checks shall be re 	n, and quantity of the drug; r administering the drug; the drug is administered; and s of person administering the for medication changes or corded and kept with the MAR appointment or consultation					
	Based on record m interview, the facili medications on the and failed to keep three of three clien findings are: Finding #1:	net as evidenced by: eview, observation and ity failed to administer e written order of a physician the MARs current affecting nts (#1, #3 and #5). The 8 of client #1's record revealed				A 	
	- 26 year old male. - Admission date of	of 12/18/17. hizophrenia, Cannabis Use				-	
	dated 11/14/18 rev	12% Rinse (antiseptic) - swish					
		8 of client #1's physician orders d order for Amoxicillin	8				
	Review on 11/27/1 MAR revealed:	8 of client #1's November 2018					-1

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Division of	Health	Service	Regulation	

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	LE CONSTRUCTION	СОМ	E SURVEY PLETED
		MHL026-857	B. WING		2012130	R 27/2018
	PROVIDER OR SUPPLIER	T11 MIDI	ddress, city, DLE ROAD EVILLE, NC	STATE, ZIP CODE 28302		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
V 118	Continued From pa	age 6	V 118			
	- Administer Amox take 1 capsule eve - Staff initials to inc	ntry for Chlorhexadine. icillin 500 milligrams (mg) - ery 8 hours (3 times a day). ficate the Amoxicillin was / 12 hours (twice daily).	*			
	 medications at app One blister pack dispensed on 11/13 10 capsules left in 					
	his medications da Finding #2: Review on 11/27/14 - 29 year old male. - Admission date o	8 of client #3's record revealed			1	ġ
	- No order for Amiti	er, Mild Intellectual ability and Gilbert Disease. iza (treats chronic constipation) ke 1 capsule twice daily.				
	dated 11/6/18 revea ordered: - Metoprolol (treats	8 of a signed FL-2 for client #3 aled the following medications high blood pressure) 25 ake 1/2 tablet (12.5mg) twice			l L	
		anxiety) 25mg - one tablet	in in Colors			
Jalan - 61	MAR revealed: - Amitiza 24 microg	3 of client #3's November 2018 grams - take 1 capsule twice nue) handwritten and no staff				

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STATEMEN	of Health Service Re TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:	ECONSTRUCTION	, (X	3) DATE SURVEY COMPLETED
		MHL026-857	B. WING			11/27/2018
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE	a. 5	
ELITE C	ARE SERVICES AT M		ULE ROAD	8302	1	
() () () () () () () () () ()	SUMMARY STA	TEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF C	ORRECTION	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	E APPROPRIA	E COMPLETE
V 118	Continued From pa	ige 7	V 118			
	- Metoprolol 25mg - twice daily.	mitiza was administered. - take 1/2 tablet (12.5mg)				
	daily at 3pm. "PRN	anxiety) 25mg - one tablet (as needed)" handwritten on ry. No staff initials to indicate is administered.		2.5	l, l,	
	Interview on 11/26/ - He received his m	18 client #3 stated: edications daily as ordered.			l	
	- 31 year old male. - Admission date of	3 of client #4's record revealed: 02/28/17. izophrenia, Autism Spectrum			1	
	Disorder, Cannabis Use Disorder. - No signed physici	Use Disorder and Alcohol an order for Topamax (treats take one tablet daily.			41	
ž.	Review on 11/27/18 2018 thru November following transcribe	3 of client #4's September er 2018 MARs revealed the d entry:				
Υ	 No staff initials to administered. No documentation 	I - take one tablet daily. Indicate the medication was the Topomov was		i da de la		
a -	discontinued	Tue topaniax was	124			
	Interview on 11/26/ his medication as o	18 client #4 stated he received rdered.	81 (₁ .)		ł	
	stated:	18 the Qualified Professional				
	pharmacy. - The facility had ch months ago.	medication orders from the anged pharmacy's several ently responsible for the			R	
Division of H	ealth Service Regulation		17			
STATE FOR	방법 것이 같이 많은 것은 것을 가지 않는 것을 가지 않는 것을 하는 것이다.		6699 Z	ZFZ11		ontinuation sheet 8 of 16

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	of Health Service R IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPL IDENTIFICATION N	UIMPED.	TIPLE CONSTRUCTION		TE SURVEY	
		MHL026-857	B. WING		1	R 1/27/2018	
	PROVIDER OR SUPPLIER	IDDLE RD	STREET ADDRESS, CIT 711 MIDDLE ROAD FAYETTEVILLE, NO)	ļ		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENC Y MUST BE PRECEDED E .SC IDENTIFYING INFORM	IES ID IY FULL PREFIX	PROVIDER'S PLAN	CTION SHOULD BE	(X5) COMPLETE DATE	ł
V 118	medications at the - He would follow u	The second second			1		
	medication administ	o accurately docum stration it could not l is received their me physician.	De		η		
V 291	10A NCAC 27G .56 (a) Capacity. A fa six clients when the developmental disa on June 15, 2001, than six clients at t provide services at	sed Living - Operati 603 OPERATIO cility shall serve no e clients have menta abilities. Any facility and providing servid hat time, may contir no more than the fa	NS more than al illness or licensed ces to more nue to all cons	ember 27 th , 2018 Elite C sumers prescribed med er will monitor weekly p	ication and avai	ilability. The h	nom
	maintained betwee qualified profession treatment/habilitati	nation. Coordinatio n the facility operate nals who are respon on or case manage the Family or Lega	n shall be or and the isible for ment. lly	<u>er will monitor weekiy</u>			Jildi
	Responsible Perso provided the oppor relationship with he means as visits to the facility. Report annually to the par- legally responsible	n. Each client shall tunity to maintain ar er or his family throu the facility and visits s shall be submitted ent of a minor reside person of an adult i	n ongoing gh such s outside I at least ent, or the resident.		1 s 1 s		
	Responsible Perso provided the oppor relationship with he means as visits to the facility. Report annually to the par- legally responsible Reports may be in conference and sh progress toward m (d) Program Activi activity opportunitie needs and the trea Activities shall be c	 Each client shall tunity to maintain ar er or his family throu the facility and visits s shall be submitted ent of a minor reside 	n ongoing gh such s outside l at least ent, or the resident. orm of a nt's als. all have choices, an. ommunity				

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	- C C	CONSTRUCTION	COM	E SURVEY PLETED
		MHL026-857	B. WING		R 11/27/20	
	PROVIDER OR SUPPLIEF	R STREET A	DDRESS, CITY, S	TATE, ZIP CODE		1
ELITE C/	ARE SERVICES AT I	MINNIEPD	DLE ROAD EVILLE, NC 28	3302	1	e
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE	(X5) COMPLET DATE
V 291	Continued From p	age 9	V 291			
		involved or when health or ome a primary concern.				
	Based on record r interview, the facil coordination betwee professionals who	net as evidenced by: reviews, observation and ity failed to maintain een the facility operator and the are responsible for the client's ig one of three audited clients are:				
	 - 31 year old male - Admission date of - Diagnoses of Sc 				, I., 8 (
	order for client #4 - Albuterol Sulfate bronchospasm) - i	8 of an electronic physician dated 04/28/18 revealed: (Ventolin-treats nhale one puff every 4 hours as ing or shortness of breath.	1		1) 1)	
	11:00am revealed - Client #4's medic with directions to a needed for wheezi	cations revealed Ventolin inhale administer every 4 hours as ing or shortness of breath. have has Ventolin inhaler while				
	stated: - Client #4 did not him while in the cc - He would follow t rescue inhaler in th	up to ensure client #4 had his ne event of shortness of breath				
SION OF HE	alth Service Regulation		6899 ZZ	FZ11	If continuation	on sheet 10 c

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:	(X3) DATE SURVEY COMPLETED
		MHL026-857	B. WING	R 11/27/2018
1999-9999-9999-9999 	PROVIDER OR SUPPLIER	TTT MID	DDRESS, CITY, STATE, ZIP CODE DLE ROAD EVILLE, NC 28302	
X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF PREFIX (EACH CORRECTIVE ACT TAG CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE COMPLETE THE APPROPRIATE DATE
V 291	Continued From pa or wheezing.	age 10	V 291	
V 367	27G .0604 Incident	t Reporting Requirements	<u>V367</u>	
	level II incidents, ex the provision of bill consumer is on the	UIREMENTS FOR	IBIS reporting and documentat	tion. All incidents will be repo
	90 days prior to the responsible for the services are provid becoming aware of be submitted on a Secretary. The rep in person, facsimile	ler rendered any service within a incident to the LME catchment area where ed within 72 hours of the incident. The report shall form provided by the port may be submitted via mail a or encrypted electronic t shall include the following		
	 reporting identification inform client ider type of ind type of ind descriptio status of cause of the incider other indian other indian 	ntification information; cident; on of incident; the effort to determine the nt; and viduals or authorities notified		
	missing or incomple shall submit an upd report recipients by day whenever: (1) the provid information provide	B providers shall explain any ete information. The provider lated report to all required the end of the next business ler has reason to believe that d in the report may be ing or otherwise unreliable; or		
	offortoodof filloroad	ng ar antainnea annanasia, ar		
	alth Service Regulation			If continuation sheet 11 of 16

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION				(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL026-857	B. WING			27/2018	
nationalisti (nationalisti) Installationalisti (nationalisti)	PROVIDER OR SUPPLIER	T11 MID	DDRESS, CITY, S DLE ROAD EVILLE, NC 2		1		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLE DATE	
V 367	required on the inc unavailable. (c) Category A and upon request by th obtained regarding (1) hospital r information; (2) reports b (3) the provid (d) Category A and of all level III incide Mental Health, Dev Substance Abuse S becoming aware of providers shall sen incidents involving Health Service Reg becoming aware of client death within s or restraint, the pro immediately, as red .0300 and 10A NC/ (e) Category A and report quarterly to t catchment area wh The report shall be by the Secretary via include summary in (1) medication definition of a level (2) restrictive the definition of a level (3) searches (4) seizures of the possession of a (5) the total n incidents that occur	der obtains information ident form that was previously d B providers shall submit, e LME, other information the incident, including: records including confidential y other authorities; and der's response to the incident. d B providers shall send a copy ent reports to the Division of velopmental Disabilities and Services within 72 hours of f the incident. Category A d a copy of all level III a client death to the Division of gulation within 72 hours of f the incident. In cases of seven days of use of seclusion wider shall report the death quired by 10A NCAC 26C AC 27E .0104(e)(18). I B providers shall send a he LME responsible for the ere services are provided. submitted on a form provided a electronic means and shall formation as follows: on errors that do not meet the II or level III incident; e interventions that do not meet evel II or level III incident; of a client or his living area; of client property or property in a client; number of level II and level III					

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STATEMEN	of Health Service F IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL026-857	(X2) MULTIPL A. BUILDING B. WING		1	SURVEY PLETED R 27/2018
	PROVIDER OR SUPPLIEI	T11 MIDD	LE ROAD	STATE, ZIP CODE		
(X4) ID PREFIX TAG	SUMMARY S	FAYETTE TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	VILLE, NC 2 ID PREFIX TAG	28302 PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTIONSHO CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD BE	(X5) COMPLETE DATE
V 367	Continued From p	page 12	V 367			
	incidents have oc meet any of the ci	e incidents whenever no curred during the quarter that riteria as set forth in Paragraphs Rule and Subparagraphs (1) Paragraph.				
(a)	Based on record r facility failed to en were submitted to	net as evidenced by: reviews and interviews the sure critical incident reports the Local Management Entity ours as required. The findings				II 9
	Response Improv - No documented	18 of the North Carolina Incident ement System revealed: level II incident reports for the eptember 2018 thru November				
	 - 31 year old male - Admission date of - Diagnoses of Sc 					
5	report for client #4 - He eloped from t	a local department store and				
	revealed: - 11/07/18 - Client was returned by th	8 of facility communication logs #4 eloped from the facility and ne local police department. #4 eloped from the facility and			1	Ĭ.

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STATEMEN	of Health Service R IT OF DEFICIENCIES OF CORRECTION	Egulation (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		MHL026-857	B. WING	· · · ·	R 11/27/2018	_
	PROVIDER OR SUPPLIER	711 MIDD	DRESS, CITY, S LE ROAD VILLE, NC 2	STATE, ZIP CODE	l	
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V 367	Interview on 11/26/ - He had resided at approximately 1 ye - He sometimes fel clients and would v - He was not able t eloped from the fac Interview on 11/26/ - He had worked at years. - Client #4 had a hi facility. - Client #4 walked of local police were in - Clients can leave called. Interview on 11/26/ - He had worked at years. - He provided 1:1 fe - Client #4 walked of years. - He provided 1:1 fe - Client #4 walked of years. - He provided 1:1 fe - Client #4 walked of years. - He police invo - The police invo - The police would gone for 3 hours. Interview on 11/27/ stated: - Client #4 had wall - He understood a be generated wher with clients at the factors	e local police department. 18 client #4 stated: t the group home for ar. t excluded from the other valk off from the group home. o state any specific dates he cility. 18 staff #1 stated: the facility for approximately 3 story of walking away from the off about 2 weeks ago and the volved. for 3 hours and then police are 18 staff #2 stated: the facility for approximately 3 or client #4 at times. offs related to client #4 olvement. be called after client #4 was 18 the Qualified Professional ked off from the facility. Level II incident report should there was police involvement acility. stitutes a recited deficiency				

Division of Health Service Regulation STATE FORM

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If continuation sheet 14 of 16

MHL026-857 B. WING R 11/27/2018 E OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 711 MIDDLE ROAD 711 MIDDLE ROAD TE CARE SERVICES AT MIDDLE RD T11 MIDDLE ROAD FAYETTEVILLE, NC 28302 100 PROVIDER'S PLAN OF CORRECTION (x5) OID (FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (x5) (x5) 736 Continued From page 14 V 736 V 736 100 NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS (c) Each facility and its grounds shall be by January 26 th , all repairs as noted but limited to will be replaced. The maintenance of the facility will be	sion of Health Service Re EMENT OF DEFICIENCIES PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY IPLETED
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