	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BOILDING		R
		MHL084-089	B. WING		03/19/2019
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE	
MOSS LA	NF II	42414 M	OSS LANE		
IIIOOO LA		NEW LO	NDON, NC 2812	7	
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE
V 000	INITIAL COMMENTS		V 000		
	on 3/19/19. The comp (Intake #NC 148779). This facility is licensed category: 10A NCAC	w up survey was completed blaint was substantiated. Deficiencies were cited.  d for the following service 27G .560)C Supervised Developmental Disabilities.			
V 318	130 .0102 HCPR - 24	·	V 318		
	10A NCAC 13O .0102 REPORTING HEALTI The reporting by heal Department of all alle personnel as defined including injuries of un done within 24 hours becoming aware of the	· · ·			
	facility failed to ensure were reported to the I Registry(HCPR) withit care facility becoming The findings are:	iew and interviews, the e allegations against staff Health Care Personnel n 24 hours of the health g aware of the allegation.  ormer client #3's (FC#3)			

Division of Health Service Regulation

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

TITLE (X6) DATE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		MHL084-089	B. WING		03/19/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE	
MOSS LA	NE II	42414 MO		_	
			OON, NC 2812		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
V 318	Continued From page	<b>:</b> 1	V 318		
V 316	Cardiomypathy, Diabout and Adjustment Disordischarged 2/1/19; legal guardian was the Services; admission assessment history of being exploactive and was home.  Review on 3/6/19 of addited 1/17/19 document/10/19 FC#3's legal concerns to the Agent FC#3 had a male at the sex offender and FC#1/11/19 meeting held to address concerns, occur and FC#3 did not staff #1 who was world and FC#3 denied; staff #1 reported the home property on 1/4 to see FC#3 but she of the group home, staff supervisor who inform have any male visitors to leave; -1/17/19 incident reported to services; -1/17/19 and 1/18/19 medically for any sign STDs, no evidence for services; -1/17, no evidence for services; -1/18/19, no evidence for services; -1/18/19 medically for any sign STDs, no evi	etes Type 2, Speech Delay der;  ne Department of Social  ent documented FC#3 had a lited by friends, sexually less.  In internal investigation ented the following: guardian (LG) reported cy's Administration (Adms) he group home who was a land sex with him; li with LG, FC#3 and Adms determined visit did not ot have sex with the male, king date of incident denied male came onto the group /19 while she was working did not allow him to enter life the staff #1 FC#3 can not so, staff #1 asked the male orted to local Adult  FC#3 was evaluated as of sexual trauma or	V 310		
	Review on 3/11/19 of Offender Registry rev -the male identified as facility was listed on t	s visiting FC#3 at the			

Division of Health Service Regulation

STATE FORM 6899 C7PO11 If continuation sheet 2 of 10

Division of	of Health Service Regu	ılation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	CONSTRUCTION	(X3) DATE SURVE	Y
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
					R	
		MHL084-089	B. WING		03/19/20	10
		MITE 004 000			03/13/20	13
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATI	E, ZIP CODE		
MOSSIA	NE II	42414 N	IOSS LANE			
MOSS LA	NE II	NEW LC	ONDON, NC 28127			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)
PREFIX	*	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULI		MPLETE DATE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROF DEFICIENCY)	RIATE	DATE
				52. 10.2.10.1,		
V 318	Continued From page	e 2	V 318			
	-been listed since 200	na·				
		n a Minor and Lewd Acts				
	with a Child.	ra winor and Lewa Acts				
	with a Office.					
	Interview on 3/14/19	with FC#3 revealed:				
	-met the male through					
		n through social media, had				
	her own cell phone;	-				
	-was coming back from an outing with staff #1					
	and client #1;					
	-client #2 was back at group home when they got					
	home;					
	,	yard at the group home;				
		e, went to her room for a				
	few minutes;	rr 110				
	-client #1, #2 and sta					
		the male, stated only				
	on her body;	ale touched her anywhere				
	-the male called for a	ride and then left:				
		mor about her and the male				
	having sex;	and about her and the male				
	-	s friends with the male.				
	,					
	Interview on 3/7/19 w	vith client #1 revealed:				
	-FC#3 had the male v	visitor;				
	-staff #1 was working	;				
		e facility, sat on the couch;				
	-FC#3 took the male	to her room, the door was				
	open;					
	-FC#3 and the male of					
	-staff #1 was sitting ri	ight there.				
	Interview on 3/11/10	with client #2 revealed:				
	-FC#3 had the male					
		e the facility, sat on couch,				
		to her room for about 5				

minutes with the door shut;

-don't think FC#3 and the male had sex;

STATE FORM 6899 If continuation sheet 3 of 10 C7PO11

Division of	of Health Service Regu	lation				
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _	<del></del>		
		MHL084-089	B. WING		R 03/19/2019	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	E, ZIP CODE		
			OSS LANE			
MOSS LA	NE II	NEW LO	NDON, NC 28127	,		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
V 318	Continued From page	2 3	V 318			
	-staff #1 was there the she told staff #1 FC# have any visitors; -staff #1 called the Te later to ask about FC# -FC#3 and the male v yard; -TL told staff #1 to tell male left.  Interview on 3/11/19 v-was returning from a -a male was in the dri-she and clients enter-she went to the bather was at the door; -FC#3 told her she had the TL won't mind; -the male came insider ug at the door; -she called the TL to a visitor; -TL reported FC#3 camake the male leave; -everyone was outsid going back and forth vabout wanting the mather male was there a -the male did not say Albemarle, only time stacility.  Review on 3/8/19 of E-report of allegations of the say and say the say and say the say and say allegations of the say allegations of the say allegations of the say allegations of the say and say allegations of the say allegatio	e whole time; 3 was not supposed to  am Lead (TL) 10 minutes #3's visitors; vent outside in the front  I the male to leave, the  with staff #1 revealed: n outing; veway at the facility; red the facility; room; of the bathroom, the male as never had company and e the facility and was on the ask can FC#3 have a male nnot have a visitor and e by this time, FC#3 was with the TL on the phone le to visit; about 20 minutes; his name, he walked from seen this male at the  DHHS IRIS revealed: of neglect against staff #1;				
	-HCPR report regardi	e of incident on 1/10/19;				

STATE FORM 6899 C7PO11 If continuation sheet 4 of 10

DIVISION	of Health Service Regu	lation			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
					R
	MHI 084-089 B. WING				
		MHL084-089			03/19/2019
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE	
			OSS LANE		
MOSS LA	NE II		NDON, NC 2812	7	
			NDON, NC 2012	.r T	
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	( - /
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	
IAG	REGULATORT OR E	100 IDENTIF TING INFORMATION)	IAG	DEFICIENCY)	VAIL
				,	
V 367	27G 0604 Incident R	eporting Requirements	V 367		
	27 O .000+ Indiacht IX	eporting requirements	' ' ' '		
	10A NCAC 27G .0604	4 INCIDENT			
	REPORTING REQUI				
	CATEGORY A AND B				
		providers shall report all			
	level II incidents, exce	•			
	during the provision of billable services or while the consumer is on the providers premises or				
		level II deaths involving			
	the clients to whom the provider rendered any service within 90 days prior to the incident to the				
	•	he catchment area where			
	services are provided				
	•	e incident. The report shall			
	be submitted on a for				
	-	t may be submitted via			
		nile or encrypted electronic			
	•	nall include the following			
	information:				
	(1) reporting pro	ovider contact and			
	identification informat				
	• •	fication information;			
	(3) type of incid	lent;			
	(4) description				
	(5) status of the	e effort to determine the			
	cause of the incident;				
	(6) other individ	luals or authorities notified			
	or responding.				
	(b) Category A and B	providers shall explain any			
	missing or incomplete	information. The provider			
		ed report to all required			
	report recipients by th	ne end of the next business			
	day whenever:				
	(1) the provider	has reason to believe that			
	information provided i	in the report may be			
	-	g or otherwise unreliable; or			
		obtains information			
		ent form that was previously			
	unavailable.	,,			

Division of Health Service Regulation

STATE FORM 6899 C7PO11 If continuation sheet 5 of 10

AND PLAN OF CORRECTION   IDENTIFICATION NUMBER:   A. BUILDING:   COMPLETED   R 03/19/2019    NAME OF PROVIDER OR SUPPLIER   STREET ADDRESS, CITY, STATE, ZIP CODE    MOSS LANE   SUMMARY STATEMENT OF DEFICIENCIES   NEW LONDON, NC 28127    (Y4) ID PREFIX   GEACH DEFICIENCY MUST BE PRECEDED BY FULL   PREFIX   CROSS-REFERENCED TO THE APPROPRIATE   DATE    TAG   COntinued From page 5   V 367    (c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including: (1) hospital records including confidential information; (2) reports by other authorities; and (3) the provider's response to the incident. (d) Category A and B providers shall send a copy of all level III incident reports to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of becoming aware of the incident. Category A providers shall send a copy of all level III incidents involving a client death to the Division of Health Service Regulation within 72 hours of becoming aware of the incident. In Page 1 to the Division of Health Service Regulation within 72 hours of becoming aware of the incident. In Page 2 to the Page 3 t	STATEMEN	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVE	
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  42414 MOSS LANE  NEW LONDON, NC 28127  (IX4) ID  PREFIX TAG  (IEACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  PREFIX TAG  (C) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including: (1) hospital records including confidential information; (2) reports by other authorities; and (3) the provider's response to the incident. (d) Category A and B providers shall send a copy of all level III incident reports to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of becoming aware of the incident. Category A providers shall send a copy of all level III incidents involving a client death to the Division of Health Service Regulation within 72	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	)
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  42414 MOSS LANE  NEW LONDON, NC 28127  (IX4) ID  PREFIX TAG  (IEACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  PREFIX TAG  (C) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including: (1) hospital records including confidential information; (2) reports by other authorities; and (3) the provider's response to the incident. (d) Category A and B providers shall send a copy of all level III incident reports to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of becoming aware of the incident. Category A providers shall send a copy of all level III incidents involving a client death to the Division of Health Service Regulation within 72							
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  42414 MOSS LANE  NEW LONDON, NC 28127   (X4) ID PREFIX TAG  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  V 367  Continued From page 5  (c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including: (1) hospital records including confidential information; (2) reports by other authorities; and (3) the provider's response to the incident. (d) Category A and B providers shall send a copy of all level III incident reports to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of becoming aware of the incident. Category A providers shall send a copy of all level III incidents involving a client death to the Division of Health Service Regulation within 72		MHL084-089 B. WING			1	110	
MOSS LANE II    A2414 MOSS LANE   NEW LONDON, NC 28127			•	1		1 00/13/20	, 10
NEW LONDON, NC 28127   (X4)   ID   SUMMARY STATEMENT OF DEFICIENCIES   (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG   (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG   (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG   (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE) TO THE APPROPRIATE DEFICIENCY)    V 367   Continued From page 5   (C) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including: (1) hospital records including confidential information; (2) reports by other authorities; and (3) the provider's response to the incident. (d) Category A and B providers shall send a copy of all level III incident reports to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of becoming aware of the incident. Category A providers shall send a copy of all level III incidents involving a client death to the Division of Health Service Regulation within 72   (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DATE OF THE APP	NAME OF P	PROVIDER OR SUPPLIER		, ,	TE, ZIP CODE		
(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  V 367  Continued From page 5  (c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including: (1) hospital records including confidential information; (2) reports by other authorities; and (3) the provider's response to the incident. (d) Category A and B providers shall send a copy of all level III incident reports to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of becoming aware of the incident. Category A providers shall send a copy of all level III incidents involving a client death to the Division of Health Service Regulation within 72	MOSS LA	ANE II			_		
PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  V 367  Continued From page 5  (c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including: (1) hospital records including confidential information; (2) reports by other authorities; and (3) the provider's response to the incident. (d) Category A and B providers shall send a copy of all level III incident reports to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of becoming aware of the incident. Category A providers shall send a copy of all level III incidents involving a client death to the Division of Health Service Regulation within 72			NEW LON	DON, NC 2812	7		
(c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including: (1) hospital records including confidential information; (2) reports by other authorities; and (3) the provider's response to the incident. (d) Category A and B providers shall send a copy of all level III incident reports to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of becoming aware of the incident. Category A providers shall send a copy of all level III incidents involving a client death to the Division of Health Service Regulation within 72	PREFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE CO	OMPLETE
(c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including: (1) hospital records including confidential information; (2) reports by other authorities; and (3) the provider's response to the incident. (d) Category A and B providers shall send a copy of all level III incident reports to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of becoming aware of the incident. Category A providers shall send a copy of all level III incidents involving a client death to the Division of Health Service Regulation within 72	V 367	Continued From page	e 5	V 367			
cases of client death within seven days of use of seclusion or restraint, the provider shall report the death immediately, as required by 10A NCAC 26C .0300 and 10A NCAC 27E .0104(e) (18).  (e) Category A and B providers shall send a report quarterly to the LME responsible for the catchment area where services are provided. The report shall be submitted on a form provided by the Secretary via electronic means and shall include summary information as follows:  (1) medication errors that do not meet the definition of a level II or level III incident;  (2) restrictive interventions that do not meet the definition of a level II or level III incident;  (3) searches of a client or his living area;  (4) seizures of client property or property in the possession of a client;  (5) the total number of level II and level III incidents that occurred; and  (6) a statement indicating that there have	V 367	(c) Category A and E upon request by the I obtained regarding the (1) hospital red information; (2) reports by C (3) the provide (d) Category A and E copy of all level III inc Division of Mental He Disabilities and Subs 72 hours of becoming Category A providers level III incidents invo Division of Health Se hours of becoming as cases of client death seclusion or restraint the death immediatel NCAC 26C .0300 and (18). (e) Category A and E report quarterly to the catchment area when The report shall be so by the Secretary via conclude summary info (1) medication definition of a level II (2) restrictive in meet the definition of incident; (3) searches of (4) seizures of in the possession of a (5) the total nuincidents that occurred	B providers shall submit, LME, other information ne incident, including: cords including confidential other authorities; and r's response to the incident. B providers shall send a cident reports to the ealth, Developmental stance Abuse Services within g aware of the incident. Is shall send a copy of all olving a client death to the strvice Regulation within 72 ware of the incident. In within seven days of use of the provider shall report y, as required by 10A d 10A NCAC 27E .0104(e) B providers shall send a the LME responsible for the the services are provided. Submitted on a form provided selectronic means and shall tormation as follows: errors that do not meet the or level III incident; interventions that do not f a client or his living area; client property or property a client; mber of level II and level III ed; and	V 367			

Division of Health Service Regulation

STATE FORM 6899 C7PO11 If continuation sheet 6 of 10

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X A. BUILDING:		1 ' '	X3) DATE SURVEY COMPLETED	
		MHL084-089	B. WING		03	R / <b>19/2019</b>
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	E, ZIP CODE		
MOSS LA	NE II		OSS LANE NDON, NC 28127			
(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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
V 367	meet any of the criter Paragraphs (a) and (	ed during the quarter that ia as set forth in	V 367			
	facility failed to ensur incidents were report for the catchment are	iew and interviews, the e all level II and level III ed to the LME responsible a where services are urs of becoming aware of				
	record revealed: -admission date of 1/s Intellectual Developm Cardiomypathy, Diab and Adjustment Disor -discharged 2/1/19; -legal guardian was tl Services; -admission assessme	etes Type 2, Speech Delay der; ne Department of Social ent documented FC#3 had a ited by friends, sexually				
	dated 1/17/19 docum -1/10/19 FC#3's legal concerns to the Agen FC#3 had a male at t sex offender and FC# -1/11/19 meeting held to address concerns, occur and FC#3 did n	guardian (LG) reported cy's Administration (Adms) he group home who was a				

Division of Health Service Regulation

STATE FORM 6899 C7PO11 If continuation sheet 7 of 10

Division of	<u>of Health Service Regu</u>	lation			
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE (	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
		MUU 00 4 000	B. WING		R
		MHL084-089	B. WIIVO		03/19/2019
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATI	E, ZIP CODE	
		42414 N	IOSS LANE		
MOSS LA	NE II	NEW LO	NDON, NC 28127		
	OLIMANA DV OT			PROVIDEDIO DI ANI OF CORDECTIO	
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD	\ · · /
TAG	,	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPI	
				DEFICIENCY)	
V 367	Continued From page	. 7	V 367		
V 307	Continued From page	<del>-</del> 1	1 307		
	and FC#3 denied;				
	-staff #1 reported the	male came onto the group			
		/19 while she was working			
	to see FC#3 but she	did not allow him to enter			
	the group home, staff	f #1 contacted her			
	supervisor who informed staff #1 FC#3 can not have any male visitors, staff #1 asked the male to leave; -1/17/19 incident reported to local Adult				
	Protective Services;				
	-1/17/19 and 1/18/19 FC#3 was evaluated				
		ns of sexual trauma or			
	STDs, no evidence for				
		charged from the facility by			
	her LG.	enargea nem are raemty 2,			
	Review on 3/11/19 of	the North Carolina Sex			
	Offender Registry rev	realed:			
	-the male identified as				
	facility was listed on t	-			
	-been listed since 200	- ·			
		a Minor and Lewd Acts			
	with a Child				
	Interview on 3/14/19 with FC#3 revealed:				
	-met the male through	h social media;			
	-talked back and forth	n through social media, had			
	her own cell phone;	-			
	-was coming back fro	m an outing with staff #1			
	and client #1;	-			
	· ·	t group home when they got			
	home;				
	•	yard at the group home;			
	_	e, went to her room for a			
	few minutes;				
	-client #1, #2 and star	ff #2 were there:			
	-denied had sex with				
		ale touched her anywhere			

on her body;

STATE FORM 6899 C7PO11 If continuation sheet 8 of 10

Division of	of Health Service Regu	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION		SURVEY
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COME	PLETED
						R
		MHL084-089	B. WING		03	/19/2019
		0.70557.4	DDD500 0171/ 07175	70.000		
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE		
MOSS LA	NE II		OSS LANE NDON, NC 28127			
(V4) ID	STIMMADA ST	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORREC		(VE)
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHO		(X5) COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPI	ROPRIATE	DATE
				DEFICIENCY)		
V 367	Continued From page	e 8	V 367			
	-the male called for a	ride and then left:				
		mor about her and the male				
	having sex;					
		s friends with the male.				
	The state of the s					
	Interview on 3/7/19 with client #1 revealed:					
	-FC#3 had the male v	•				
	-staff #1 was working					
	-the male came inside facility, sat on the couch;					
	-FC#3 took the male to her room, the door was					
	open; -FC#3 and the male did not have sex;					
	-staff #1 was sitting ri	gnt there.				
	Interview on 3/11/19	with client #2 revealed:				
	-FC#3 had the male					
		e the facility, sat on couch,				
		to her room for about 5				
	minutes with the door	shut;				
	-don't think FC#3 and	I the male had sex;				
	-staff #1 was there the whole time;					
	-she told staff #1 FC#3 was not supposed to					
	have any visitors;					
		eam Lead (TL) 10 minutes				
	later to ask about FC					
	-FC#3 and the male went outside in the front					
	yard;	I the male to leave the				
	male left.	I the male to leave, the				
	maic icit.					
	Interview on 3/11/19	with staff #1 revealed:				
	-was returning from a					
	-a male was in the dr	G.				
	-she and clients enter					
	-she went to the bath					
	-when she came out	of the bathroom, the male				

was at the door;

the TL won't mind;

-FC#3 told her she has never had company and

STATE FORM 6899 C7PO11 If continuation sheet 9 of 10

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					B) DATE SURVEY COMPLETED	
		MHL084-089	B. WING		03	R 3/ <b>19/2019</b>
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	ZIP CODE	•	
MOSS LA	NE II		OSS LANE NDON, NC 28127			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
V 367	rug at the door; -she called the TL to visitor; -TL reported FC#3 ca make the male leave -everyone was outsic going back and forth about wanting the mathe male was there at the male did not say Albemarle, only time facility.  Review on 3/8/19 of incident occurred on facility became awardincident report regar	e the facility and was on the ask can FC#3 have a male annot have a visitor and ; de by this time, FC#3 was with the TL on the phone ale to visit; about 20 minutes; his name, he walked from seen this male at the  DHHS IRIS revealed: 11/4/19; re of incident on 1/10/19; rding the allegation FC#3 poroved male visitor at the	V 367			

Division of Health Service Regulation

STATE FORM 6899 C7PO11 If continuation sheet 10 of 10