STATEMENT OF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA         AND PLAN OF CORRECTION       IDENTIFICATION NUMBER:		(X2) MULTIPLE C		(X3) DATE SURVEY COMPLETED C 06/17/2019		
			A. BUILDING:			
	MHL041-752		B. WING			
IAME OF PF	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE		
ORRELL	GROUP HOME		ORRELL STREET			
			SBORO, NC 27406			
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
∨ 000	INITIAL COMMENTS A complaint survey was completed on 6/17/19. The complaint was unsubstantiated (intake #NC00152040). Deficiencies were cited.		V 000			
	category: 10A NCAC	d for the following service 27G .5600C Supervised se Primary Diagnosis is a bility.				
V 110	27G .0204 Training/S Paraprofessionals	Supervision	V 110			
	SUPERVISION OF F (a) There shall be no paraprofessionals. (b) Paraprofessional associate professional professional as speci Subchapter. (c) Paraprofessional knowledge, skills and population served. (d) At such time as a employment system then qualified profess professionals shall de (e) Competence shal exhibiting core skills (1) technical knowle (2) cultural awarene (3) analytical skills; (4) decision-making (5) interpersonal ski (6) communication s (7) clinical skills. (f) The governing bo develop and impleme	fied in Rule .0104 of this s shall demonstrate l abilities required by the a competency-based is established by rulemaking, sionals and associate emonstrate competence. Il be demonstrated by including: dge; ss;				

Division of Health Service Regulation         STATEMENT OF DEFICIENCIES         AND PLAN OF CORRECTION         (X1) PROVIDER/SUPPLIER/CLIA         IDENTIFICATION NUMBER:         MHL041-752		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		IDENTIFICATION NOT NON				
		B. WING		06	C 06/17/2019	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	, ZIP CODE		
GORRELL	GROUP HOME		ORRELL STREET SBORO, NC 27406			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
V 110	Continued From page 1		V 110			
	plan upon hiring each paraprofessional.					
	This Rule is not met as evidenced by:					
	Based on record reviews and interviews the facility failed to ensure one of two staff (staff #1)					
	demonstrated knowledge and skills required by					
	the population served					
	Review on 6/17/19 of staff #1's personnel record					
	revealed:					
	-A hire date of 12/17/18; -A job description for a paraprofessional;					
		trainings were completed on				
	-	aining was completed on				
	that included:	form completed on 5/30/19				
	-Staff was utilizir working;	ng electronic devices while				
		ended from 6/7/19-6/10/19.				
	Review on 6/13/19 o -An admission date o	f client #1's record revealed:				
		declared incompetent and				
	was appointed a Gua	•				
		Impulse Control Disorder,				
		evelopmental Disability, an				
	intracranial injury and					
		with staff #1 revealed:				
		rdinator arrived at the facility				
		0pm on 5/23/19 to visit with				
	him; alth Service Regulation					

Division of Health Service Regulation STATE FORM

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
		DENTITION TOTAL ON DELA.				
	MHL041-752		B. WING		C 06/17/2019	
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE,	, ZIP CODE		
GORRELI	L GROUP HOME		ORRELL STREET SBORO, NC 27406			
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 110	Continued From page	e 2	V 110			
	-All 3 of the clients w -"I had my electronic me;" -He had been using f movie; -"I just paused it like -The care coordinato #1 had no sheets on wearing 2 adult briefs -He thought since the sheets, he would lear instead have the clief -"I didn't know it (no s issue;" -"The sheets were cle on his bed;" -"He (client #1) gets hours;" -The client had been -"I'm new to this;" -"That's (putting 2 ad only way I knew to ke -"I'm still in the proce -He had not consider diaper more frequent requirement of every -He had been workin months and had prev facility owned by the Interview on 6/13/19 -He had assisted the training staff #1; -Staff #1 had not beet training and presente everything. Interviews on 6/13/19	ere in their bedrooms; device (game system) with his game system to watch a I usually do;" r had asked him why client his bed and why he was a that were both wet; e client continuously wet the ve them off the bed and nt lie on 2 changing pads; sheets on the bed) was an ean and in his room but not changed every couple of wearing 2 adult briefs; ult briefs on the client) the eep this contained;" ss of learning;" ed changing client #1's ly than the minimum 2 hours; g at the facility for 1 1/2 riously worked at another Licensee. with staff #2 revealed: Program Director with en open to learning during the ed as if he already knew				

STATE FORM

P7RQ11

If continuation sheet 3 of 4

STATEMENT OF DEFICIENCIES         (X1) PROVIDER/SUPPLIER/CLIA           AND PLAN OF CORRECTION         IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED C	
		A. BUILDING:			
	MHL041-752	B. WING		06	5/17/2019
OVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE,	ZIP CODE		
GROUP HOME					
(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
Continued From page 3		V 110			
-She wasn't sure of s current facility but the since the 1st week of -Since the incident w additional staff had b from 6:00pm - 9:00pt	staff #1's start date at the bught he had worked there f April 2019; rith client #1 on 5/23/19, an been working with staff #1				
	OF DEFICIENCIES F CORRECTION OVIDER OR SUPPLIER GROUP HOME SUMMARY ST (EACH DEFICIENC REGULATORY OR Continued From pag toileting, transferring -She wasn't sure of s current facility but the since the 1st week o -Since the incident w additional staff had b	F CORRECTION       IDENTIFICATION NUMBER:         IDENTIFICATION NUMBER:       IDENTIFICATION NUMBER:         OVIDER OR SUPPLIER       STREET/         GROUP HOME       1309 GG         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       SUMMARY STATEMENT OF DEFICIENCIES         Continued From page 3       toileting, transferring, and eating; -She wasn't sure of staff #1's start date at the current facility but thought he had worked there since the 1st week of April 2019; -Since the incident with client #1 on 5/23/19, an additional staff had been working with staff #1 from 6:00pm - 9:00pm to ensure clients received	OF DEFICIENCIES F CORRECTION       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:       (X2) MULTIPLE CC A. BUILDING:         MHL041-752       B. WING         OVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE GROUP HOME         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       ID PREFIX TAG         Continued From page 3       V 110         toileting, transferring, and eating; -She wasn't sure of staff #1's start date at the current facility but thought he had worked there since the 1st week of April 2019; -Since the incident with client #1 on 5/23/19, an additional staff had been working with staff #1 from 6:00pm - 9:00pm to ensure clients received	OF DEFICIENCIES F CORRECTION       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:       (X2) MULTIPLE CONSTRUCTION A. BUILDING:         OVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE         GROUP HOME       1309 GORRELL STREET GREENSBORO, NC 27406         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       ID PREFIX TAG       PROVIDER'S PLAN OI (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC         Continued From page 3       V 110       V 110         Continued From page 3       V 110	OF DEFICIENCIES F CORRECTION       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:       (X2) MULTIPLE CONSTRUCTION A. BUILDING:       (X3) DATI COM         MHL041-752       B. WING       B. WING       06         OVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE       06         GROUP HOME       T309 GORRELL STREET GREENSBORO, NC 27406       06         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)         Continued From page 3       V 110       V 110         toileting, transferring, and eating; -She wasn't sure of staff #1's stat date at the current facility but though the had worked there since the 1st week of April 2019; -Since the incident with Client #1 on 5/23/19, an additional staff had been working with staff #1 from 6:00pm - 9:00pm to ensure clients received       V 110

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