AND DIAN OF CORRECTION INDENTIFICATION NUMBER:		, ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED				
		A. BUILDING:			R-C			
		MHL034-336	B. WING					
NAME OF D	DOVIDED OD SUDDI IED	etheet A	DDDESS CITY STA	TE ZIR CODE				
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE								
HOME CA	HOME CARE SOLUTIONS AT INLAND DRIVE 719 INLAND DRIVE KERNERSVILLE, NC 27284							
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / 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 000	INITIAL COMMENTS		V 000					
	on 9/25/19. The comp (intake #NC00153890 This facility is licensed category: 10A NCAC	v up survey was completed plaint was unsubstantiated b). Deficiencies were cited. d for the following service 27G .5600C Supervised be Primary Diagnosis is a lility.						
V 132	G.S. 131E-256(G) HC Allegations, & Protect		V 132					
	G.S. §131E-256 HEALTH CARE PERSONNEL REGISTRY (g) Health care facilities shall ensure that the Department is notified of all allegations against health care personnel, including injuries of unknown source, which appear to be related to any act listed in subdivision (a)(1) of this section. (which includes: a. Neglect or abuse of a resident in a healthcare facility or a person to whom home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided. b. Misappropriation of the property of a resident in a health care facility, as defined in subsection (b) of this section including places where home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided. c. Misappropriation of the property of a healthcare facility. d. Diversion of drugs belonging to a health care facility or to a patient or client. e. Fraud against a health care facility or against a patient or client for whom the employee is providing services). Facilities must have evidence that all alleged							

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

(X6) DATE TITLE

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING			X3) DATE SURVEY COMPLETED	
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NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	E, ZIP CODE	-	
HOME CA	RE SOLUTIONS AT INLA	ND DRIVE	AND DRIVE SVILLE, NC 2728	4		
(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 (EACH CORRECTIVE AC' CROSS-REFERENCED TO ' DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
V 132	investigations must be	om harm while the gress. The results of all e reported to the e working days of the initial	V 132			
	facility failed to notify Registry (HCPR) of a against health care po- internal investigation, (former client (FC) #3 Reviews on 7/24/19 a	ews and interviews, the the Health Care Personnel in allegation of abuse ersonnel and conduct an affecting 1 of 3 clients). The findings are: and 9/24/19 of facility records				
	notified of allegations Interviews on 7/24/19 revealed: -The day program he where he resided wer individuals; -He had informed his program he attended sexually abused by a -His 1 on 1 worker wa discussed the allegati	and 7/26/19 with FC #3 attended and the facility re owned by the same 1 on 1 worker at the day on 7/24/19 that he had been staff member; as present with him when he on with law enforcement; red by anyone at the facility				

Division of Health Service Regulation

STATE FORM 5D3T11 If continuation sheet 2 of 7

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING: _	COMPLETED		
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		MHL034-336 B. WING		R-C 09/25/2019	
			1		09/23/2019
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE, ZIP CODE	
HOME CA	RE SOLUTIONS AT INLA	AND DRIVE 719 INLAN			
		KERNERS	SVILLE, NC 272	884	
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE
V 132	Continued From page	e 2	V 132		
	the Qualified Profess -She had not notified of abuse or conducte -She was made awar Operating Officer (CC had talked with FC #3 but she wasn't provid Interviews on 7/24/19 the COO revealed: -He was made aware 7/24/19 that FC #3 ha sexually abused him; -Staff #1 was still emp medical leave; -"[Staff #1] was one co -The detective that in had informed him tha be unsubstantiated; -"[FC #3] has a strong truth;" -"[Staff #1] is not a ho -He was not aware th notified of the allegati investigation had not	the HCPR of the allegation d an internal investigation; re on 7/24/19 by the Chief DO) that law enforcement 3 regarding some allegations led with details. 9, 7/26/19 and 9/25/19 with e by law enforcement on ad alleged that staff #1 ployed but was out on of our better workers;" terviewed FC #3 on 7/24/19 it the allegation was going to g history of not telling the comosexual type of person;" lat the HCPR was not ion and that an internal been completed; illity of the QP to notify HCPR to complete internal			
V 367	27G .0604 Incident R	Reporting Requirements	V 367		
		REMENTS FOR			

Division of Health Service Regulation

STATE FORM 5D3T11 If continuation sheet 3 of 7

PRINTED: 09/25/2019 FORM APPROVED

Division of Health Service Regulation

MHL034-336 B. WING B. WING R.C 09/25/2019 STREET ADDRESS, CITY, STATE, ZIP CODE 719 INLAND DRIVE KERNERSVILLE, NC 27284 V367 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST as PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG Continued From page 3 W 367 Continued From page 3 the provider from page 3 the providers premises or level III incidents and level II deaths involving the clients to whom the provider rendered any service within 90 days prior to the incident to the LME responsible for the catchment area where services are provided within 72 hours of becoming aware of the incident. The report shall be submitted on a form provided by the Secretary. The report may be submitted via mail, in person, facsimle or encrypted electronic means. The report shall include the following information; (1) reporting provider contact and identification information; (2) client identification information; (3) type of incident; (4) description of incident; (5) status of the effort to determine the cause of the incident, and (6) other individuals or authorities notified or responding. (b) Category A and B providers shall explain any missing or incomplete information. The provider shall submit an updated report to all required report recipients by the end of the next business	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED				
MHL034-336 B. WING O9725/2019 STREET ADDRESS, CITY, STATE, ZIP CODE THOME CARE SOLUTIONS AT INLAND DRIVE SUMMARY STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MISTS OF PRECEDED BY FULL TAGS V 367 Continued From page 3 the provision of billable services or while the consumer is on the providers premises or level III incidents and level III deaths involving the clients to whom the provider provider day service within 90 days prior to the incident to the LME responsible for the catchment area where services are provided within 72 hours of becoming aware of the incident. The report shall be submitted on a form provided by the Secretary. The report shall include the following information: (1) reporting provider contact and identification information; (2) client identification information; (3) type of incident; (4) description of incident; (5) status of the effort to determine the cause of the incident; (6) other individuals or authorities notified or responding. (b) Category A and B providers shall explain any missing or incomplete information. The provider shall submit an updated report to all required report recipients by the end of the next business			A. BUILDING: _	A. BUILDING:					
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the provision of billable services or while the consumer is on the providers premises or level III incidents and level II deaths involving the clients to whom the provider rendered any service within 90 days prior to the incident to the LME responsible for the catchment area where services are provided within 72 hours of becoming aware of the incident. The report shall be submitted on a form provided by the Secretary. The report may be submitted via mail, in person, facsimile or encrypted electronic means. The report shall include the following information: (1) reporting provider contact and identification information; (2) client identification information; (3) type of incident; (4) description of incident; (5) status of the effort to determine the cause of the incident; and (6) other individuals or authorities notified or responding. (b) Category A and B providers shall explain any missing or incomplete information. The provider shall submit an updated report to all required report recipients by the end of the next business	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF	BE COMF	PLETE		
consumer is on the providers premises or level III incidents and level II deaths involving the clients to whom the provider rendered any service within 90 days prior to the incident to the LME responsible for the catchment area where services are provided within 72 hours of becoming aware of the incident. The report shall be submitted on a form provided by the Secretary. The report may be submitted via mail, in person, facsimile or encrypted electronic means. The report shall include the following information: (1) reporting provider contact and identification information; (2) client identification information; (3) type of incident; (4) description of incident; (5) satus of the effort to determine the cause of the incident; and (6) other individuals or authorities notified or responding. (b) Category A and B providers shall explain any missing or incomplete information. The provider shall submit an updated report to all required report recipients by the end of the next business	V 367	Continued From page	e 3	V 367					
(1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or (2) the provider obtains information required on the incident form that was previously unavailable. (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;	V 307	the provision of billable consumer is on the provider son the provider son the provider son days prior to the in responsible for the caservices are provided becoming aware of the submitted on a for Secretary. The report in person, facsimile of means. The report in person, facsimile of means. The report in formation: (1) reporting pridentification informat (2) client identification informat (3) type of incident (4) description (5) status of the cause of the incident (6) other indivision responding. (b) Category A and Emissing or incomplete shall submit an updar report recipients by the day whenever: (1) the provided information provided erroneous, misleadin (2) the provided required on the incident unavailable. (c) Category A and Emportation request by the sobtained regarding the obtained regarding the obtained regarding the obtained regarding the obtained regarding the content of the provided regarding the obtained reg	ole services or while the roviders premises or level III deaths involving the clients rendered any service within incident to the LME atchment area where it within 72 hours of the incident. The report shall improvided by the rt may be submitted via mail, or encrypted electronic shall include the following the following the effort to determine the grand duals or authorities notified. By provider shall explain any the information. The provider ted report to all required the end of the next business or has reason to believe that in the report may be go or otherwise unreliable; or robtains information tent form that was previously a providers shall submit, LME, other information the incident, including:	V 307					

Division of Health Service Regulation

STATE FORM 5D3T11 If continuation sheet 4 of 7

Division of	of Health Service Regu	lation			
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		
MHL034-336		B. WING			
NAME OF D	ROVIDER OR SUPPLIER	CTDEET	ADDRESS, CITY, STA	TE ZIR CODE	09/25/2019
NAME OF FI	NOVIDER OR SUFFLIER		AND DRIVE	I.E., ZIF GODE	
HOME CA	RE SOLUTIONS AT INLA	AND DRIVE	RSVILLE, NC 272	284	
(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 CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
V 367	(d) Category A and B of all level III incident Mental Health, Develor Substance Abuse Serbecoming aware of the providers shall send a incidents involving a commendation of the Health Service Regulates a service Regulates and the commendate of the client death within service or restraint, the providing aware of the client death within service or restraint, the providing aware of the cated and 10A NCAC (e) Category A and B report quarterly to the catchment area where the report shall be subjected by the Secretary via expectation of a level II (2) restrictive in the definition of a level II (2) restrictive in the definition of a level (3) searches of (4) seizures of the possession of a commendate of the possession of a commendate of the courre (6) a statement been no reportable in incidents have occurrence any of the criteria.	d's response to the incident. It providers shall send a copy reports to the Division of opmental Disabilities and roices within 72 hours of the incident. Category A the copy of all level III client death to the Division of the incident. In cases of the incident of the death red by 10A NCAC 26C to 27E .0104(e)(18). It providers shall send a services are provided. It is provided to the incident of t	V 367		

This Rule is not met as evidenced by:

STATE FORM 6899 5D3T11 If continuation sheet 5 of 7

MAME OF PROVIDER OR SUPPLIER **PROVIDER OR SUPPLIER** **HOME CARE SOLUTIONS AT INLAND DRIVE** **HEREIX** **HOME CARE SOLUTIONS AT INLAND DRIVE** **HEREIX** **HEREIX**
MOME CARE SOLUTIONS AT INLAND DRIVE KERNERSVILLE, NC 27284 CAU ID SUMMARY STATEMENT OF DEFICIENCIES PRECEDED BY FULL PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE) TO THE APPROPRIATE DAYE OF CROSS-REFERENCE) TO TH
PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE REQUATORY OR LSC IDENTIFYING INFORMATION) V 367 Continued From page 5 Based on record reviews and interviews the facility failed to ensure critical incident reports were submitted to the Local Management Entity (LME) within 72 hours as required. The findings are. Reviews on 7/24/19 and 9/24/19 of the Incident Response Improvement System for the facility revealed no reports submitted regarding an allegation of staff #1 abusing former client (FC) #3. Interviews on 7/24/19 and 7/26/19 with FC #3 revealed: -The day program he attended and the facility where he resided were owned by the same individuals; -He had informed his 1 on 1 worker at the day program he attended on 7/24/19 that he had been sexually abused by a staff member at the facility; -His 1 on 1 worker was present with him when he discussed the allegation with law enforcement; -He had not been asked by anyone at the facility to provide details of the abuse. Interviews on 7/24/19, 9/24/19 and 9/25/19 with
Based on record reviews and interviews the facility failed to ensure critical incident reports were submitted to the Local Management Entity (LME) within 72 hours as required. The findings are. Reviews on 7/24/19 and 9/24/19 of the Incident Response Improvement System for the facility revealed no reports submitted regarding an allegation of staff #1 abusing former client (FC) #3. Interviews on 7/24/19 and 7/26/19 with FC #3 revealed: -The day program he attended and the facility where he resided were owned by the same individuals; -He had informed his 1 on 1 worker at the day program he attended on 7/24/19 that he had been sexually abused by a staff member at the facility; -His 1 on 1 worker was present with him when he discussed the allegation with law enforcement; -He had not been asked by anyone at the facility to provide details of the abuse. Interviews on 7/24/19, 9/24/19 and 9/25/19 with
-She had not submitted an incident report regarding the allegation of abuse; -She was made aware on 7/24/19 by the Chief Operating Officer (COO) that law enforcement had talked with FC #3 regarding some allegations but she wasn't provided with details. Interviews on 7/24/19, 7/26/19 and 9/25/19 with the COO revealed: -He was made aware by law enforcement on 7/24/19 that FC #3 had alleged that staff #1

Division of Health Service Regulation

STATE FORM 5D3T11 If continuation sheet 6 of 7

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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE (A. BUILDING:	CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED				
MHL034-336			B. WING			R-C /25/2019			
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE									
HOME CA	ARE SOLUTIONS AT INLA	AND DRIVE	ND DRIVE SVILLE, NC 2728	84					
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE!	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETE DATE			
V 367	medical leave; -"[Staff #1] was one of a control of the detective that in the had informed him the be unsubstantiated; -"[FC #3] has a stron truth;" -"[Staff #1] is not a horder of the was not aware the submitted regarding of the leaves of	of our better workers;" Iterviewed FC #3 on 7/24/19 It the allegation was going to g history of not telling the Indicate the process of the p	V 367						

Division of Health Service Regulation

STATE FORM 5D3T11 If continuation sheet 7 of 7