## PRINTED: 11/04/2019 FORM APPROVED

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: MHL084056		. ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		B. WING	10	10/24/2019		
AME OF PF	ROVIDER OR SUPPLIER	STREET	DDRESS, CITY, STATE	, ZIP CODE		
OWDER	REUNION GROUP HOME		OWDER REUNION   ARLE, NC 28001	ROAD		
(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 ACT CROSS-REFERENCED TO 1 DEFICIENC	CTION SHOULD BE COMPL D THE APPROPRIATE DATE	
V 000	INITIAL COMMENTS		V 000			
	One of the two comple (Intakes #NC156472, was cited. This facility is licensed category: 10A NCAC	as completed on 10/23/19. aints was substantiated #NC156683). A deficiency d for the following service 27G .5600C Supervised Developmental Disabilities.				
V 111	27G .0205 (A-B) Assessment/Treatme		V 111			
	PLAN (a) An assessment sl client, according to go to the delivery of serv not be limited to: (1) the client's prese (2) the client's needs (3) a provisional or a established diagnosis of admission, except to detoxification or other shall have an establis admission; (4) a pertinent social history; and (5) evaluations or as psychiatric, substance vocational, as approp (b) When services ar establishment and im treatment/habilitation	TATION OR SERVICE hall be completed for a overning body policy, prior ices, and shall include, but nting problem; s and strengths; idmitting diagnosis with an determined within 30 days that a client admitted to a 24-hour medical program hed diagnosis upon l, family, and medical sessments, such as e abuse, medical, and riate to the client's needs. e provided prior to the plementation of the or service plan, hereafter in," strategies to address				

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Division of Health Service Regulat STATEMENT OF DEFICIENCIES () AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		MUL 094050	B. WING		10/24/2019		
	IAME OF PROVIDER OR SUPPLIER STREET A			ADDRESS, CITY, STATE, ZIP CODE			
		33973 L	OWDER REUNION F				
OWDER	REUNION GROUP HOM	E	ARLE, NC 28001				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED T( DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE	
V 111	Continued From pag	e 1	V 111				
	facility failed to ensur	as evidenced by: /iew and interviews, the re assessments were the needs of the client					
	Review on 10/7/19 o -admission on 10/21/ -diagnoses of Profou	nd Intellectual					
	Cerebral Palsy and L Incontinence;						
	with last update on 9 picks at his skin arou	s Assessment dated 2/15/19 /18/19 documented client #1 nd his finger nails, scratches hits objects with his hands					
	-behavior support pla documented self inju						
		ealed: to check client #1 for					
	-now staff must chec change per safety pla -client #1 bruises eas	sily;					
		If injurious behaviors. of client #1's body checks					

Division of Health Service Regulation STATE FORM

H70111

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Division of Health Service Regulation           STATEMENT OF DEFICIENCIES         (X1) PROVIDER/SUPPLIER/CLIA           AND PLAN OF CORRECTION         IDENTIFICATION NUMBER:			. ,	E SURVEY PLETED		
			7/0 0005	10	10/24/2019	
	33973 L					
REUNION GROUP HOM	ALBEM	ARLE, NC 28001				
(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE A CROSS-REFERENCED T	ACTION SHOULD BE COMP TO THE APPROPRIATE DAT		
Continued From page 2		V 111				
documentation for the month of August 2019 revealed the following dates no body check was documented: 8/10, 8/11, 8/12, 8/14-8/21, 8/25, 8/27. Review on 10/7/19 of a form titled "Safety Plan Protocol" dated 9/6/19 completed by the Qualified Professional (QP) documented the following: -body checks will be completed on client #1 during each shift (8am, 4pm, 8pm); -any marks will be documented.						
#1's body checks rev body checks were no daily on each shift: 9	vealed the following dates ot completed three times /8, 9/10, 9/11, 9/12, 10/5,					
revealed: -will ensure body che needed for the safety -will train staff on how	ecks are completed as / plan for client #1; w to document properly on					
	ROVIDER OR SUPPLIER REUNION GROUP HOM SUMMARY S <sup>-</sup> (EACH DEFICIENC REGULATORY OR Continued From pag documentation for th revealed the followin documented: 8/10, 8 8/27. Review on 10/7/19 o Protocol" dated 9/6/1 Qualified Professiona following: -body checks will be during each shift (8a -any marks will be do Review on 10/10/19 #1's body checks rev body checks were no daily on each shift: 9 10/6, 10/8, 10/9 10/1 Further interview on revealed: -will ensure body checks needed for the safety -will train staff on how	DF CORRECTION       IDENTIFICATION NUMBER:         IDENTIFICATION NUMBER:       IDENTIFICATION NUMBER:         MHL084056       33973 L         REUNION GROUP HOME       33973 L         ALBEM       SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         Continued From page 2       documentation for the month of August 2019 revealed the following dates no body check was documented: 8/10, 8/11, 8/12, 8/14-8/21, 8/25, 8/27.         Review on 10/7/19 of a form titled "Safety Plan Protocol" dated 9/6/19 completed by the Qualified Professional (QP) documented the following: -body checks will be completed on client #1 during each shift (8am, 4pm, 8pm); -any marks will be documented.         Review on 10/10/19 of documentation of client #1's body checks revealed the following dates body checks were not completed three times daily on each shift: 9/8, 9/10, 9/11, 9/12, 10/5, 10/6, 10/8, 10/9 10/10.         Further interview on 10/124/19 with the QP	IDENTIFICATION NUMBER:       A. BUILDING:         MHL084056       B. WING         ROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE,         REUNION GROUP HOME       33973 LOWDER REUNION F         ALBEMARLE, NC 28001       ALBEMARLE, NC 28001         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       ID PREFIX TAG         Continued From page 2       V 111         documentation for the month of August 2019 revealed the following dates no body check was documented: 8/10, 8/11, 8/12, 8/14-8/21, 8/25, 8/27.       V 111         Review on 10/7/19 of a form titled "Safety Plan Protocol" dated 9/6/19 completed by the Qualified Professional (QP) documented the following: -body checks will be completed on client #1 during each shift (8am, 4pm, 8pm); -any marks will be documented.       ID Review on 10/10/19 of documented.         Review on 10/10/19 of documented three times daily on each shift: 9/8, 9/10, 9/11, 9/12, 10/5, 10/6, 10/8, 10/9 10/10.       ID Further interview on 10/124/19 with the QP revealed: -will ensure body checks are completed as needed for the safety plan for client #1; -will train staff on how to document properly on	PF CORRECTION       IDENTIFICATION NUMBER:       A. BUILDING:         MHL084056       B. WING         ROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       ID PREFIX         Continued From page 2       V 111         Continued From page 2       V 111         documentation for the month of August 2019 revealed the following dates no body check was documented: 8/10, 8/11, 8/12, 8/14-8/21, 8/25, 8/27.       V 111         Review on 10/7/19 of a form titled "Safety Plan Protocol" dated 9/6/19 completed by the Qualified Professional (QP) documented the following: -body checks will be completed on client #1 during each shift (8am, 4pm, 8pm); -any marks will be documented.       History and a set to be completed the following dates body checks were not completed three times daily on each shift: 9/8, 9/10, 9/11, 9/12, 10/5, 10/6, 10/8, 10/9 10/10.       History and client #1; -will ensure body checks are completed as needed for the safety plan for client #1; -will ensure body checks are completed as needed for the safety plan for client #1; -will train staff on how to document properly on	OF CORRECTION       IDENTIFICATION NUMBER:       A. BUILDING:       10         MHL084056       B. WING       10         REUNION GROUP HOME       STREET ADDRESS, CITY, STATE, ZIP CODE       33973 LOWDER REUNION ROAD         ALBEMARLE, K.C. 28001       Image: Common complex street address, city, state, ZIP code       10         SUMMARY STATEMENT OF DEFICIENCIES       Image: Common complex street address, city, state, ZIP code       PROVIDER'S PLAN OF CORRECTION ALLEMARLE, K.C. 28001         Continued From page 2       V 111       PREFIX       PROVIDER'S PLAN OF CORRECTION HOULD BE CORRECTION IN A PROPRIATE DEFICIENCY:         Continued From page 2       V 111       Occommentation for the month of August 2019       PREFIX       PROVIDER'S PLAN OF CORRECTION PROPRIATE DEFICIENCY:         Continued From page 2       V 111       Occommentation for the month of August 2019       PREFIX       PROVIDER'S PLAN OF CORRECTION PROPRIATE DEFICIENCY:         Continued From page 2       V 111       Occommentation of Complex on body check was documented: 8/10, 8/11, 8/12, 8/14-8/21, 8/25, 8/27.       V111       Image: Complex on 10/7/19 of a form titled "Safety Plan Protocol" dated 9/6/19 completed by the Qualified Professional (QP) documented the following cates body checks were not completed by the Qualified Professional (QP) documented.       Image: Complex on 10/10/19 of documented.         Review on 10/10/19 of documentation of client #11       Unix on 10/19 of 10/10.       Image: Complex on 10/124/19 with	

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