Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
					R
		MHL080-164	B. WING		11/06/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE. ZIP CODE	
			TH FRANKLIN S		
CABARRI	JS COUNTY GROUP HO	ME 5 CHINA G			
(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 SHOULD	BE COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	RIATE DATE
				DEFICIENCY)	
V 000	INITIAL COMMENTS		V 000		
	An annual and follow	up survey was completed			
	on 11/6/19. A deficier	ncy was cited.			
	TI : 6 - 99 - 1 - 9				
		d for the following service			
		27G .5600C Supervised Developmental Disabilities.			
	Living for Addits with	Developmental Disabilities.			
V 110	27C 0204 Training/C	unondolon	V 110		
V 110	27G .0204 Training/S Paraprofessionals	supervision	V 110		
	raiapiolessionais				
	10A NCAC 27G .0204 COMPETENCIES AND				
	SUPERVISION OF PARAPROFESSIONALS				
	(a) There shall be no privileging requirements				
	for paraprofessionals				
		s shall be supervised by an			
	associate professiona				
		fied in Rule .0104 of this			
	Subchapter.	a shall domonatrate			
	(c) Paraprofessionals	abilities required by the			
	population served.	abilities required by the			
	(d) At such time as a	competency-based			
	employment system i	· · · · · · · · · · · · · · · · · · ·			
	rulemaking, then qual	lified professionals and			
	associate professiona	als shall demonstrate			
	competence.				
		ll be demonstrated by			
	exhibiting core skills i	_			
	(1) technical knowle(2) cultural awarene	_			
	(2) cultural awarene(3) analytical skills;	33,			
	(4) decision-making;				
	(5) interpersonal skil				
	(6) communication s				
	(7) clinical skills.				
(f) The governing body for each facility shall					
	-	nt policies and procedures			
	for the initiation of the	individualized supervision			

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

TITLE (X6) DATE

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		MHL080-164	B. WING		11	R 1 /06/2019
	ROVIDER OR SUPPLIER JS COUNTY GROUP HO!	106 SOL	ADDRESS, CITY, STATE JTH FRANKLIN STF GROVE, NC 28023			
(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)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
V 110	Continued From page plan upon hiring each		V 110			
	facility failed to ensure	iew and interviews, the e staff demonstrated abilities required by the				
	revealed: -hire date of 3/2/15 wi Manager; -completed updated ti	staff #1's personnel record ith job title of Group Home rainings in the following: 11/19 and Getting It Right				
	-admission date of 2/7 -diagnoses of Intellec Disability-Severe, Spe Diabetes and Hyperte -per admission docun	tual Developmental eech and Sound Disorder, ension; nentation client #3 y slowly and needs more				
	8/14/19 regarding clie -client #3 alleged staf bed by his shirt while	f #1 pulled him out of the on vacation at the beach; essed and ready to depart				

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	i rieaitii Service Regu				1		
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING: _		COMPLETED			
				R			
MHL080-164		B. WING		11/06/2019			
		WITIL000-104			1 11/00/2019		
NAME OF P	ROVIDER OR SUPPLIER	STREET A	TE, ZIP CODE				
	106 SOUTH FRANKLIN STREET						
CABARRU	JS COUNTY GROUP HOI	ME 5 CHINA G	ROVE, NC 2802	3			
()(4) ID	STIMMADV ST.	ATEMENT OF DEFICIENCIES	- 15	PROVIDER'S PLAN OF CORRECTION	J (V5)		
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \		
TAG	*	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF			
				DEFICIENCY)			
V 110	Continued From page	2	V 110				
	. •						
	-client #3 went back a	and laid back down on the					
	bed;						
		as having difficulty getting					
	client #3 to get up from						
		staff tried to prompt client					
	•	s it was time to depart;					
	•	ulled client #3 up by his arm					
	and led him out of the	e bedroom.					
		the internal investigation					
		8/27/19 regarding the					
	-	client #3 regarding staff #1					
	revealed:						
		ministrator, Administrator					
	Assistant and the Qua	•					
	· · · · · · · · · · · · · · · · · · ·	ded pending the completion					
	of the investigation;						
		nt #3 and other clients were					
	inconsistent;						
	-client #3 also added	_					
	slapped him twice on						
	•	ted he lied about the abuse;					
		took client #3 by his arm					
	to get him up off the b	ped.					
	Intervious == 44/0/40	with stoff #41 revealed					
		with staff #1 revealed:					
	•	with client #3, other staff					
	and other clients;	anto the prior pight of the					
		ents the prior night of the					
		vacation accommodations					
	for the next morning;	the staff's avacatations for					
		the staff's expectations for					
		arding packing belongings					
		ave at check out time;					
		t client up in the morning,					
		and was already dressed;					
	-time to leave and clie						
	commons area with o	ther clients;	1				

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-found client #3 had laid back down in the bed

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PRINTED: 11/06/2019

Division o	of Health Service Regul	lation			FORM	APPROVED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		MHL080-164	B. WING		11/0	R 06/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	ODRESS, CITY, STA	TE, ZIP CODE		
CABARRI	JS COUNTY GROUP HO	MF 5	TH FRANKLIN S ROVE, NC 2802			
(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	(X5) COMPLETE DATE
V 110	Continued From page	3	V 110			
	from the bed; -other staff also tried to of the bed; -took client #3 by his a the bed; -client #3 would get u onto the bed; -pulled client #3 up se get him to get up; -client #3 got up and I -started to go back int -staff #1 stood in front hands up and stopped bedroom; -later allegations were client #3; -was suspended durin and was allowed to co allegations were dete -denied ever hit or hu -did try to get client #3 arm the day of depart accommodations.	to bedroom; It of client #3 and put her It of client #3; It of client #3; It of client #3; It of client #3 revealed: It is of client #3				

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client #3;

out of the bed;

-investigated allegations staff #1 mistreated

-staff #1 did take client #3 by his arm to get him

-will ensure staff #1 completes training on more

-determined allegations were not true;

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C	CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
						R
		MHL080-164	B. WING			/06/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	E, ZIP CODE		
CABARRI	JS COUNTY GROUP HO	MES	JTH FRANKLIN ST			
	CLIMMADY CT		SROVE, NC 28023		CORRECTION	0.5
(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 C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
V 110	Continued From page	2 4	V 110			
V 110		es to situations with client	V 110			

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