STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL084-090		(X2) MULTIPLE CO	(X3) DATE SURVEY COMPLETED			
		IDENTIFICATION NUMBER.	A. BUILDING:		R 12/20/2019	
		B. WING				
NAME OF PR	ROVIDER OR SUPPLIER	STREET	DDRESS, CITY, STATE	, ZIP CODE		
		235 COC	GIN AVENUE			
JUGGINS	GROUP HOME	ALBEM	ARLE, NC 28001			
(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 CORRECT (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLET	
V 000	INITIAL COMMENTS	3	V 000			
	on 12/20/19. The con (Intake #NC 157707) This facility is license category: 10A NCAC	w up survey was completed nplaint was substantiated . A deficiency was cited. d for the following service 27G .560)C Supervised				
V 108	27G .0202 (F-I) Pers	Developmental Disabilities.	V 108			
	 (g) Employee trainin provided and, at a mi following: (1) general organiza (2) training on client delineated in 10A NC 10A NCAC 26B; 	tion shall be documented. g programs shall be inimum, shall consist of the				
	 client as specified in plan; and (4) training in infecti bloodborne pathoger (h) Except as permitt .5602(b) of this Subc 	the treatment/habilitation ous diseases and ns. ed under 10a NCAC 27G hapter, at least one staff ilable in the facility at all				
	member shall be train including seizure man to provide cardiopulm trained in the Heimlic techniques such as the the American Heart A equivalence for reliev (i) The governing bo	ned in basic first aid nagement, currently trained nonary resuscitation and th maneuver or other first aid hose provided by Red Cross, Association or their ving airway obstruction.				
	reporting, investigatin	supplier Representative's Signatur		TITLE	(X6) DATE	

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

HGQ711

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED R	
		MHL084-090	B. WING			к /20/2019
NAME OF PI	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE,	ZIP CODE		
OGGINS	GROUP HOME		GGIN AVENUE ARLE, NC 28001			
(X4) ID	SUMMARY ST			PROVIDER'S PLAN O	F CORRECTION	(X5)
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	THE APPROPRIATE	COMPLET
V 108	Continued From pag	e 1	V 108			
	and communicable d clients.	liseases of personnel and				
	This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to ensure staff completed training to meet the mh/dd/sa needs of the client for 2 of 4 staff (#3 and #4) and 1 of 1 former staff(FS#5). The findings are:					
	-admission date of 8, -diagnoses of Intellec Disabilities Mild, Atte Disorder and Anti-Pe -treatment plan dated #1 was "grossly sexu and female staff," ex confrontation, had se	ctual Developmental ention Deficit Hyperactivity ersonality Disorder; d 8/16/19 documented client ually inappropriate with male hibited inappropriate sexual exual behaviors, had a history nappropriately, rubbed his				
	records revealed: -staff #3 was hired of Direct Care and there training on clients with behaviors and sexual record; -staff #4 was hired of Direct Care and there training on clients with	and 12/18/19 of personnel n 4/30/18 with the job title of e was no documentation of th inappropriate sexual al aggression present in the n 10/7/19 with the job title of e was no documentation of th inappropriate sexual al aggression present in the 7/13/18, terminated on				

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			
		MHL084-090	B. WING		12	R 2/20/2019
NAME OF PI	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE,	ZIP CODE		
COGGINS	GROUP HOME		GGIN AVENUE			
			ARLE, NC 28001			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 108	Continued From pag	e 2	V 108			
	training on clients with inappropriate sexual behaviors and sexual aggression present in the record. Interview on 12/18/19 with staff #3 revealed: -worked as needed at the facility with client #1; -client #1 invaded her personal space a lot; -tried to take her phone away from her; -twice blocked her in a room; -threatened to molest her; -stopped working with him at that facility; -threatened to rape of her female co-workers; -not completed training in clients with sexual behaviors.					
	-worked a few times -worked third shift on -tried to touch her, to -told her he was goin anus; -felt uncomfortable w -did not work with hir -had done her trainin client #1 used to resi	n again; ig at the sister facility where de; 1 before and he did not act in				
	behaviors; -initially client #1 did -made changes and client #1 at the facilit behaviors; -client #1 was in the returning to the facilit	d: o staff about client #1's not exhibit these behaviors; had male staff working with y who had training in sexual hospital and was not				

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Division of Health Service Regulation STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C	(X3) DATE COM	(X3) DATE SURVEY COMPLETED		
			A. BUILDING:		R	
		MHL084-090	B. WING		12	2/20/2019
IAME OF PF	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE		
OGGINS	GROUP HOME		GGIN AVENUE			
			ARLE, NC 28001			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEN	CTION SHOULD BE CON THE APPROPRIATE	
V 108	Continued From pa	ge 3	V 108			
	This deficiency con and must be correc	stitutes a re-cited deficiency ted within 30 days.				
	Ith Service Regulation					