	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION		E SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COM	PLETED	
		MHL065-264	IL065-264 B. WING			C 04/02/2020	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE			
		28 BEAU		VE			
WILMING	GTON HOME	WILMING	TON, NC 284	12			
(X4) ID			ID			(X5) COMPLET	
PREFIX TAG		YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN(THE APPROPRIATE	DATE	
V 000	INITIAL COMMENT	ſS	V 000				
		was completed on April 2,					
		nts were substantiated 344, #NC00161303,					
		ficiencies were cited.					
	#NOOUTO10000J. DC						
	This facility is licens	sed for the following service					
	category: 10A NCA	C 27G .5600C Supervised					
	Living for Adults wit	h Developmental Disabilities.					
V 110	27G .0204 Training	Supervision	V 110				
	Paraprofessionals	Supervision	VIIO				
	·						
		04 COMPETENCIES AND					
		PARAPROFESSIONALS					
		no privileging requirements for					
	paraprofessionals.	als shall be supervised by an					
		nal or by a qualified					
		cified in Rule .0104 of this					
	Subchapter.						
	(c) Paraprofession	als shall demonstrate					
		nd abilities required by the					
	population served.						
		a competency-based					
		n is established by rulemaking, ssionals and associate					
		demonstrate competence.					
		all be demonstrated by					
	exhibiting core skills						
	(1) technical knowl						
	(2) cultural awaren						
	(3) analytical skills;						
	(4) decision-makin(5) interpersonal sl						
	(6) communication						
	(7) clinical skills.	Shino, and					
		oody for each facility shall					
		nent policies and procedures					
		he individualized supervision					
ision of H	ealth Service Regulation	•	r I				

STATE FORM

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
				A. BUILDING:		С
		MHL065-264	B. WING			02/2020
IAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
WILMINGTON HOME			JREGARD DRIN GTON, NC 284			
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN(THE APPROPRIATE	COMPLET DATE
V 110	Continued From pa	ige 1	V 110			
	plan upon hiring ea	ch paraprofessional.				
	This Rule is not me Based on record re	et as evidenced by: views and interviews, 1 of 4				
		rect care staff audited (Staff				
		strate knowledge, skills, and the population served. The				
	Review on 4/1/2020) of Staff #6's personnel file				
	revealed: -Date of Hire: 12/9/	10				
	-Position, direct car	e paraprofessional staff.				
	-Staff #6's trainings	s included: ise and Neglect of Individuals				
		Developmental Disabilities				
		lient Rights son Centered Thinking				
		-				
	Review on 3/31/202 revealed:	20 of client #2's record				
	-36 year old female	admitted 10/15/19.				
		d mild intellectual and bilities, infantile cerebral				
	palsy, paraplegic-sp					
	-Individual Service	Plan (ISP) dated 10/15/19				
		#2 was her own guardian, and ht to her to make her own				
		sis Plan within the ISP				
	documented "being	treated like a child" may				
	increase her stress	and trigger a crisis.				
	Telephone interview	v on 3/26/2020 client #2's Care	e			
	Coordinator stated:					

STATE FORM

Z7D011

If continuation sheet 2 of 14

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: C C MHL065-264 B. WING C 04/02/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 28 BEAUREGARD DRIVE VILMINGTON, NC. 28412 VILMINGTON HOME 28 DEAUREGARD DRIVE WILMINGTON, NC. 28412 PROVIDER'S PLAN OF CORRECTION CORRECTION YAID SUMMARY STATEMENT OF DEFICIENCES WILMINGTON, NC. 28412 PROVIDER'S PLAN OF CORRECTION CORRECTION YO 110 Continued From page 2 V 110 PREFIX Collent #2 reported to her in February 2020 that Staff #6 had removed her food because she did not want client #2 to "make a mess" and was going to "teach her a lesson." V 110 V 110 V 110 - The Group Home Manager/ Qualified Professional (GHM/QP) had discussed at a staff meeting the need to get client #2 out of her room to eat her meals, but, she had the right to eat in her room in she made this choice. The GHM/QP coached ther #2 shout oh her som and an on-coming coworker, Staff #1 new without feeling forced. There was an incident when Staff #1 served client #2 shout oh her and notified the GHM/QP. Staff #1 heard client #2 shout oh her and notified the GHM/QP. Staff #1 heard client #2 shout oh her and notified the GHM/QP. Staff #1 heard client #2 shout oh her and notified the GHM/QP. Staff #1 heard client #2 shout oh her and notified the GHM/QP. Staff #1 heard client #2 shout oh her and notine her an notimer weat her food as she at staff #1 heard	Division	of Health Service Re	egulation				IAPPROVED
MHL065-264 B. WING						(X3) DATE SURVEY COMPLETED	
VILNINGTON HOME 28 BEAUREGARD DRIVE WILLINGTON, NC. 28412 [X4], ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC DENTIFYING INFORMATION) IP PREFIX TAG PREVIDENCY CONSCREPTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCES ACTION DEFICIENCY COME DEFICIENCY V 110 -Client #2 reported to her in February 2020 that Staff #6 had removed her food because she did not want client #2 to 'make a mess'' and was going to 'teach her a lesson." -Staff #1 returned her meal to her immediately. Telephone interview on 3/31/2020 Staff #1 stated: -The Group Home Manager/ Qualified Professional (GHM/QP) had discussed at a staff meeting the need to get client #2 out of her room to eat her meals, but, she had the right to eat in her room is her made this choice. The GHM/QP coached the staff how to approach client #2 to encourage her to come out and interact with others at meal time without feeling forced. -There was an incident when Staff #1 heard client #2 'shout' and could tell she was uspect. Staff #6, went to client #2's food to her and notified the GHM/QP. Staff #1 hwas in another part of the home when the food was taken and did not hear any conversation between client #2 and Staff #6. -Staff			MHL065-264	B. WING		C 04/02/2020	
VILMINGTON HOME WILMINGTON, NC 28412 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH OER/CENCY WIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTIVE (EACH OER/RECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) OVER OVER V 110 V 110 Continued From page 2 -Client #2 reported to her in February 2020 that Staff #6 had removed her food away as she was eating in her room. -Staff #7 had removed her food because she did not want client #2 to "make a mess" and was going to "teach her a lesson." -Staff #1 returned her meal to her immediately. V 110 Telephone interview on 3/31/2020 Staff #1 stated: -The Group Home Manager/ Qualified Professional (GHM/QP) had discussed at a staff meeting the need to get client #2 out of her room to eat her meals, but, she had the right to eat in her room if she made this choice. The GHM/QP coached the staff how to approach client #2 to encourage her to come out and interact with others at meal time without feeling forced. -There was an incident when Staff #1 served client #2 in her room and on -coming coworker, Staff #6, went to client #2's food to her and notified the GHM/QP. Staff #1 was in another part of the home when the food was taken and did not hear any conversation between client #2 and Staff #6. -Staff #1 thought Staff #6 was trying to follow recent directions of the GHM/QP to encourage	NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	TATE, ZIP CODE		
WUMING ION, NC 28412 (X1)ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PROVIDER'S PLAN OF CORRECTION SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Common DEFICIENCY) V 110 Continued From page 2 V 110 V 110 -Client #2 reported to her in February 2020 that Staff #6 had removed her food because she did not want client #2 to "make a mess" and was going to "teach her a lesson." Staff #6 had removed her food because she did not want client #2 to "make a mess" and was going to "teach her a lesson." -Staff #1 returned her meal to her immediately. Telephone interview on 3/31/2020 Staff #1 stated: -The Group Home Manager/ Qualified Professional (GHM/QP) had discussed at a staff meeting the need to get client #2 out of her room to eat her meals, but, she had the right to eat in her room if she made this choice. The GHM/QP coached the staff how to approach client #2 to encourage her to come out and interact with others at meal time without feeling forced. -There was an incident when Staff #1 served client #2 in her room and an on-coming coworker, Staff #6, went to client #2's room and removed her food as she ate. Staff #1 heard client #2 "shout" and could tell she was upset. Staff #1 returned Client #2's food to her and notified the GHM/QP. Staff #1 thought Staff #0 was trying to follow recent directions of the GHM/QP to encourage Figure 24			28 BEAU		VE		
PAGE TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH OCRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Common the common should be cross-referenced to the common should be deficiency Common the common should be cross-referenced to the common should be deficiency Common the common should be cross-referenced to the common should be deficiency Common the common should be deficiency Common the common should be cross-referenced to the common deficiency Common the common should be deficiency Common the common should be deficiency Common the common deficiency Common the common should be deficiency Common should be de	VVILIVIIIN	STON HOME	WILMING	STON, NC 284	12		
-Client #2 reported to her in February 2020 that Staff #6 took her food away as she was eating in her room. -Staff #6 had removed her food because she did not want client #2 to "make a mess" and was going to "teach her a lesson." -Staff #1 returned her meal to her immediately. Telephone interview on 3/31/2020 Staff #1 stated: -The Group Home Manager/ Qualified Professional (GHM/QP) had discussed at a staff meeting the need to get client #2 out of her room to eat her meals, but, she had the right to eat in her room if she made this choice. The GHM/QP coached the staff how to approach client #2 to encourage her to come out and interact with others at meal time without feeling forced. -There was an incident when Staff #1 served client #2 in her room and an on-coming coworker, Staff #6, went to client #2's room and removed her food as she ate. Staff #1 heard client #2 "shout" and could tell she was upset. Staff #1 returned client #2's food to her and notified the GHM/QP. Staff #1 was in another part of the home when the food was taken and did not hear any conversation between client #2 and Staff #6. -Staff #1 hought Staff #6 was trying to follow recent directions of the GHM/QP to encourage	PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACT CROSS-REFERENCED TO	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
Staff #6 took her food away as she was eating in her room. -Staff #6 had removed her food because she did not want client #2 to "make a mess" and was going to "teach her a lesson." -Staff #1 returned her meal to her immediately. Telephone interview on 3/31/2020 Staff #1 stated: -The Group Home Manager/ Qualified Professional (GHM/QP) had discussed at a staff meeting the need to get client #2 out of her room to eat her meals, but, she had the right to eat in her room if she made this choice. The GHM/QP coached the staff how to approach client #2 to encourage her to come out and interact with others at meal time without feeling forced. -There was an incident when Staff #1 served client #2 in her room and an on-coming coworker, Staff #6, went to client #2's room and removed her food as she ate. Staff #1 heard client #2 "shout" and could tell she was upset. Staff #1 returned client #2's food to her and notified the GHM/QP. Staff #1 was in another part of the home when the food was taken and did not hear any conversation between client #2 and Staff #6. -Staff #1 thought Staff #6 was trying to follow recent directions of the GHM/QP to encourage	V 110	Continued From pa	ige 2	V 110			
 did not think Staff #6 was trying to be punitive toward client #2. Telephone interview on 4/1/2020 Staff #6 stated: -In mid-February 2020 she arrived for her shift and client #2 was eating in her room. -The GHM/QP had held a meeting 1-2 days prior and informed staff that client #2 was not to eat in her room because it was causing bugs. -She removed client #2's food and returned it to the kitchen, where client #2 could eat. 		Staff #6 took her for her room. -Staff #6 had remove not want client #2 to going to "teach her -Staff #1 returned her -Staff #1 returned her -Staff #1 returned her -The Group Home Professional (GHM meeting the need to to eat her meals, but her room if she mat coached the staff her encourage her to co others at meal time -There was an incide client #2 in her room Staff #6, went to cli her food as she ate "shout" and could to returned client #2's GHM/QP. Staff #1 home when the foo any conversation bo -Staff #1 thought Si recent directions of client #2 to come of did not think Staff # toward client #2. Telephone interview -In mid-February 20 and client #2 was e -The GHM/QP had and informed staff to her room because -She removed client	od away as she was eating in wed her food because she did o "make a mess" and was a lesson." her meal to her immediately. w on 3/31/2020 Staff #1 stated: Manager/ Qualified /QP) had discussed at a staff o get client #2 out of her room ut, she had the right to eat in de this choice. The GHM/QP ow to approach client #2 to ome out and interact with without feeling forced. dent when Staff #1 served m and an on-coming coworker, ent #2's room and removed b. Staff #1 heard client #2 ell she was upset. Staff #1 food to her and notified the was in another part of the d was taken and did not hear etween client #2 and Staff #6. taff #6 was trying to follow the GHM/QP to encourage ut of her room for meals. She t6 was trying to be punitive				

		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE			
ND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		СОМ	PLETED
		MHL065-264	B. WING			C 02/2020
AME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
/11 MINI/		28 BEAU		VE		
	STON HOME	WILMING	GTON, NC 284	12		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 110	Continued From pa	ge 3	V 110			
	-Before she could n	otify the GHM/QP Staff #1				
	had already called h	nim.				
		d client #2's food she told the				
		eting and staff had been told				
	room.	not suppose to eat in her				
		d the food client #2 started				
	crying.					
		lient #2's food to her room.				
		able to get client #2 to come to	0			
	the kitchen and finis					
		nt #2 wanted to eat in her				
		s be permitted, Staff #6 stated ent #2 could eat in her room	1			
		bugs. Client #2 could not help				
		she ate. Staff have to clean				
		she did not have a problem				
	with this.					
		discussed client rights at staff				
		ld not recall his discussing a				
	client's right to eat i	n their room. Id eat out of her room with				
	everyone else.	d eat out of her foorn with				
		ceived any disciplinary				
		al counseling or warning, for				
		s food. Staff #6 stated she did				
		ng; she was following the				
		e. In her opinion Staff #1				
		vritten up. Staff #1 had been a				
	was not to eat in he	he GHM/QP told staff client #2 r room	<u>-</u>			
	Telephone interview	on 3/26/2020 the GHM/QP				
	stated:					
		a aware of an incident in				
		nt #2 had chosen to eat her	,			
	before she finished	and Staff #6 removed her food	1			
		nded Staff #6 for this. Staff #6				

TATEMENT OF DEFICIENCIES	egulation (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		A. BUILDING:			0
	MHL065-264	B. WING			C 02/2020
IAME OF PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
VILMINGTON HOME		REGARD DRI			
	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
	/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	THE APPROPRIATE	COMPLET DATE
V 110 Continued From pa	ige 4	V 110			
dining room. The r warning.	eprimand was a verbal				
-He had no docume	entation of the reprimand				
	erbal warning and these were				
	Vhen he gave a verbal staff they would be written up				
	the schedule for a few days if				
there was another					
	ient's rights to make their own				
	ekly staff meetings. He had				
	ould make there own were there to support them in				
living their lives.					
V 115 27G .0208 Client S	ervices	V 115			
10A NCAC 27G .02	208 CLIENT SERVICES				
	ovide activities for clients shall				
assure that:					
	ervision is provided to ensure				
the safety and welfa	itable for the ages, interests,				
	litation needs of the clients				
served; and					
	te in planning or determining				
activities.					
	grams designated or described 24-hour" shall make services	1			
	a day, every day in the year.				
unless otherwise sp					
(c) Facilities that se	erve or prepare meals for				
	that the meals are nutritious.				
. ,	no have a physical handicap				
with secure adaptiv	e vehicle shall be equipped				
	pre preschool children who				
require special ass	stance with boarding or riding				
	nsported in the same vehicle,				
there shall be one a	adult, other than the driver, to				

Division	of Health Service Re	equiation			FORMAPPROVE
STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		MHL065-264	B. WING		C 04/02/2020
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S ⁻	TATE, ZIP CODE	
	GTON HOME	28 BEAU	IREGARD DRI	VE	
		WILMING	GTON, NC 284	12	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE COMPLETE THE APPROPRIATE DATE
V 115	Continued From pa	ge 5	V 115		
	assist in supervision	-			
	This Rule is not met as evidenced by: Based on interviews, the facility failed to make services available 24 hours a day affecting 1 of 2 clients audited (client #2) and ensure nutritious meals for 1 of 2 clients audited (client #1). The findings are:				
	revealed: -36 year old female -Diagnoses include developmental disa palsy, paraplegic-sp -Individual Service documented client s that it was importan decisions. The Cris documented "being	d mild intellectual and bilities, infantile cerebral			
	coordinator stated: -There had there be wheel chair beginni 2019. Her wheel ch -Client #2 stayed in Day Program) for a -There were issues were battery issues company identified	y on 3/26/2020 client #2's care een issues with client #2's ng around Thanksgiving, nair would not hold a charge. the home (did not attend her week during this time. with the charger, then there , and finally the repair the underlying problem and it o fault of the facility that it took			

Division	of Health Service Re	egulation			FORM APPROVED
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		MHL065-264	B. WING		C 04/02/2020
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE	
WILMING	STON HOME		REGARD DRI		
			GTON, NC 284		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI) CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD BE COMPLETE THE APPROPRIATE DATE
V 115	Continued From pa	ige 6	V 115		
	so long to get it rep to the repair compa	aired. These delays were due any response.			
	Telephone interview on 2/26/2020, 3/30/2020, and 4/2/2020 the Group Home Manager/Qualified Professional (GHM/QP) stated: - There had been some battery issues starting around December 2019 with client #2's wheel chair. - There had been one occasion he had to give a verbal counseling to Staff #3 and a former staff because they transported client #2 to the Day Program even though the client had requested to stay at home because of her wheel chair malfunction. - The decision to transport her to the Day Program was made primarily by the terminated staff and Staff #3 accompanied them. - The reason staff took client #2 to the Day Program (when she wanted to stay home) was to attend a staff meeting. Finding #2: Review on 3/27/2020 and 3/31/2020 of client #1's record revealed: -35 year old female admitted 5/7/09. -Diagnoses included severe intellectual and developmental disabilities; BPAN (Beta-Propeller Protein-Associated Neurogeneration); seizures;				
	Anomaly Lissencep Lobes; and, Chroni -Client #1's level of	phally-Bilateral Temporal c constipation. participation had decreased and was expected to continue or BPAN diagnosis.			
Division of H	Telephone interviev Program Director s mechanical diet. Th	v on 3/26/2020 client #1's Day tated client #1 was on a soft here were times the group a nutrition bar and client #1's			

TATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
					С
	MHL065-264	B. WING		04/	02/2020
NAME OF PROVIDER OR SUPPLIER		DRESS, CITY, S			
WILMINGTON HOME		REGARD DRI TON, NC 284			
().=	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLET DATE
V 115 Continued From pa	age 7	V 115			
mother said she co	ould not have it.				
Telephone interview	w on 3/27/2020 client #1's Care				
Coordinator stated					
	sent her a picture on #1's lunch sent to the Day				
Program from the	Group Home.				
	she could see chunks of meat				
in mashed potatoe	s. a lot of weight due to her				
	and was about 5 pounds from				
needing a feeding					
	1 loved to eat. Now with her				
She was losing her	on, she would forget to chew. r sense of taste.				
	w on 4/1/2020 client #1's				
guardian stated:	there had been on issue at the				
	there had been an issue at the rding client #1's lunch.				
	sured this was taken care of by				
	lanager/Qualified Professional				
(GHM/QP). -Client #1's syndro	me contributed to her weight				
	ost 30 lbs. She now weighed				
100.5 pounds and	when it got low enough they				
	e a feeding tube. Client #1				
caused swallowing	e problems in her throat that problems.				
Telephone interview	w on 3/26/2020 the GHM/QP				
-There had been 1	issue with client #1's diet.				
	a mechanical soft diet and staff				
	mashed potatoes to her Day hey could be mashed together.				
	pared by the 3rd shift staff; he				
	he staff were that prepared the				
meal.	a shaff mosting and shaff built				
-He covered this in	a staff meeting and staff had				

	of Health Service Re					
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			СОМ	E SURVEY PLETED
	MHL065-264		B. WING			C 02/2020
IAME OF F	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, ST	TATE, ZIP CODE		
VILMINO	GTON HOME		REGARD DRING TON, NC 284			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
V 115	Continued From pa	ge 8	V 115			
	been instructed to p through the food pr	out all of client #1's food ocessor.				
V 540	27F .0103 Client Ri Grooming	ghts - Health, Hygiene And	V 540			
	dignity, privacy and of personal health, Such rights shall ind to the: (1) opportunit daily, or more often (2) opportunit (3) opportunit barber or a beautici (4) provision paper and soap for individual personal indigent client. Such not limited to toothp napkins, tampons, sutensil. (b) Bathtubs or sho individual privacy sho (c) Adequate toilets	Il be assured the right to humane care in the provision hygiene and grooming care. clude, but need not be limited ty for a shower or tub bath as needed; ty to shave at least daily; ty to obtain the services of a an; and of linens and towels, toilet each client and other hygiene articles for each n other articles include but are paste, toothbrush, sanitary shaving cream and shaving owers and toilets which ensure nall be available. s, lavatory and bath facilities y a client with a mobility				
	facility failed to assudignity and humane	s and record reviews, the ure the the client's right to e care in the provision of I grooming for 1 of 2 clients				

Division	of Health Service Re	aulation	FORM APPROVED				
STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED	
		MHL065-264	B. WING			C 02/2020	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
	GTON HOME		REGARD DR				
			TON, NC 28			1	
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V 540	Continued From pa	ge 9	V 540				
Division of H	record revealed: -35 year old female -Diagnoses included developmental disa Protein-Associated Anomaly Lissencep Lobes; and, Chronid -She had developed sacrum that require -Client #1's Daily Tu was to be turned ev and wound status to The Log had a colu diaper was wet or d Review on 3/27/202 Service Plan (ISP) o -Client #1's level of over the prior year a to decline due to he - Full support was re tasks. -She was incontinen for yeast growing be contractures; and r diet. -Diligence was need at the group home to toothbrush. -She would usually sponge bath in the o incontinence issues -Finger nails needed to -A bib/apron was needed	d severe intellectual and bilities; BPAN (Beta-Propeller Neurogeneration); seizures; hally-Bilateral Temporal c constipation. d pressure ulcers over her d home health nursing care. urn Schedule documented she rery 2 hours while in her bed o be updated with every turn. mn to document if the client's ry. 20 of client #1's Individual dated 6/1/19 revealed: participation had decreased and was expected to continue or BPAN diagnosis. equired for all daily hygiene ht; required close monitoring etween her fingers due to equired a soft mechanical ded when brushing her teeth wice daily, using her electric shower in the morning and evening do address a. d to be trimmed close;					

Division of Health Service Regulation STATE FORM

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY PLETED
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MHL06		MHL065-264	B. WING		04/	02/2020
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V 540	Continued From pa	ge 10	V 540			
	Daily Turn Schedule revealed: -Documentation of consistent. Example -1/31/2020 at 9:5 right; wound status on 2/1/2020 at 7 an status was "open." -2/2/2020 staff de #1 at 4:10 am, and The next entry was on her left side. In status was "open, " "wet." -2/3/2020 staff de #1 at 2 am and pos next entry was 2/3/2 her right side. In bo status was "open" a -2/3/2020 staff de #1 at 9:10 am posit next entry was 2/4/2 the client had been the clients wound s -2/4/2020 staff de #1 at 9:35 am posit next entry was 2/5/2 her left side. In bot status was "open." -2/5/2020 staff de #1 at 7:30 am posit next entry was 2/7/2 her right. In both et was "open." -Wound status doc 2/13/2020 through 2	50 pm client was turned to the , "open." The next entry was n, turned to her left and wound bocumented they turned client positioned on her right side. 2/2/2020 at 7 am, positioned both entries the clients wound and her diaper had been locumented they turned client sitioned on her left side. The 2020 at 5:05 am, positioned or oth entries the clients wound and her diaper had been "wet." pocumented they turned client ioned on her right side. The 2020 at 7:58 am. It was noted on her back. In both entries tatus was "open." pocumented they turned client ioned on her right side. The 2020 at 7:30 am; positioned or h entries the clients wound coumented they turned client ioned on her right side. The 2020 at 7:30 am; positioned or h entries the clients wound pocumented they turned client ioned on her left side. The 2020 at 7:20 am; positioned or h entries the clients wound status umented, "closed" from				
	Guardian stated:	v on 3/31/2020 client #1's				

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CUEUL#1 HAO CONSIDESS IN DELEVES ADO 1000							
around her mouth.			mess in her eyes, and lood				
-She had received pictures from client #1's family			pictures from client #1's family				
vision of Health Service Regulation	vision of H			I			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		MHL065-264	B. WING			C 04/02/2020	
IAME OF F	PROVIDER OR SUPPLIER	STREET AD	DDRESS, CITY, STATE, ZIP CODE				
		28 BEAU		VE			
VILIVIING	STON HOME	WILMING	TON, NC 284	12			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE ⁻ DATE	
V 540	Continued From page 12		V 540				
	hand is particularly poor nail hygiene h -In the pictures she could see what the She had been able clothing, jagged fing -On 2/20/20 picture were taken at the D could see some bu teeth, and it looked brushed. She could of one of client #1's Telephone Interview Program Director s	received from family she family was concerned about. to see evidence food on her gernails, crusts in her eyes. s were sent by the family that bay Program. In the photos she ild up of something on her like her teeth needed to be d also see a crust on the side s eyes. w on 3/26/2020 client #1's Day tated:					
	around 10:30 am. -Over the past few greatly improved. -There had been tin her eyes or a film o	arrived at the Day Program months client #1's care had nes she may have crusts in n her teeth. Client #1's eyes say if this precipitates the					
	crustiness. -She had not seen arrived. Client #1's -Client #1 had a bo	food on her clothing when she					
	-Client #1 had a his sacrum and had nu She noted a small a ago and called the Qualified Professio #1 seen right away inch in size. She th	story of bedsores on her irsing visits for wound care. area of breakdown not long Group Home Manager/ nal (GHM/QP). He had client . The area was less than 1 hought this happened after the 11/27/19). Nursing visits					
	resumed and the a	rea healed right away.					

Division of Health Service Regulation STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: MHL065-264		IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED		
		B. WING		C 04/02/2020			
AME OF	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	TATE, ZIP CODE			
A/11 MINI/	GTON HOME	28 BEAU	REGARD DRI	VE			
		WILMING	STON, NC 284	12		1	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE COMPLET THE APPROPRIATE DATE		
V 540	Continued From pa	age 13	V 540				
	mother that her fing properly. Her nails what the mother wa them "square," not the mother had bee wanted client #1's n scratched herself. -When client #1's n went to see the clie odor. -He had been told h client #1's eyes wa "crustiness." Her g throughout the day mouth and eye card due to medications -Client #1 wore dia dropped in on a Sa said her diaper had log in place for staf changes/checks ey documented they h prior to mother's ar Schedule.	a complaint from client #1's ger nails had not been cut had been cut short, which is anted, but the staff had cut rounded. He was not sure if en this specific about how she hails cut. Client #1 had not nother had complained, he ent. The client did not have an by the Day Program staff that ter and she accumulates gums also bleed easily and she required ongoing e. Her bleeding gums may be she took, but he was not sure. pers. Client #1's mother turday in February 2020 and i not been changed. We had a f to document diaper very 2 hours. The staff had had changed her diaper 1 hour rival on the client's Daily Turn					