Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		
			A. BUILDING.			
		MHL012-137 B. WING		C 10/30/2020		
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE ZIP CODE		
NAME OF F	NOVIDEN ON 301 1 EIEN		KER LANE	TE, ZII GODE		
PARK PL	ACE		NTON, NC 28655	;		
(X4) ID				PROVIDER'S PLAN OF CORRECTIO	N (X5)	
PREFIX TAG	,	/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE	
V 000	INITIAL COMMENTS		V 000			
	30, 2020. The complation (intake #NC00168671 sister facility is identificated facility will be identified will be identified using numerical identifier. This facility is licensed). A deficiency was cited. A ed in this report. The sister d as sister facility A. Staff is sister facility A and a d for the following service 27G.1300 Residential				
V 108	27G .0202 (F-I) Perso	onnel Requirements	V 108			
	(g) Employee training provided and, at a min following: (1) general organiza: (2) training on client delineated in 10A NC. 10A NCAC 26B; (3) training to meet to client as specified in the plan; and (4) training in infection bloodborne pathogen: (h) Except as permitte. 5602(b) of this Subchmember shall be avaitimes when a client is member shall be trainincluding seizure man to provide cardiopulm trained in the Heimlich.	ion shall be documented. If programs shall be nimum, shall consist of the stional orientation; rights and confidentiality as AC 27C, 27D, 27E, 27F and the mh/dd/sa needs of the he treatment/habilitation ous diseases and st. In the distribution of the standard on the st				

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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	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:	A. BUILDING:	COMPLETED
MHL012-137	B. WING	C - 10/30/2020
	EET ADDRESS, CITY, STATE, ZIP CODE	
109	PARKER LANE	
PARK PLACE	RGANTON, NC 28655	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)	PREFIX (EACH CORRECT TAG CROSS-REFEREIT	PLAN OF CORRECTION (X5) CTIVE ACTION SHOULD BE NCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETE DATE
equivalence for relieving airway obstruction. (i) The governing body shall develop and implement policies and procedures for identifying reporting, investigating and controlling infectious and communicable diseases of personnel and clients. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure at least one staff (Staff #3) who was trained in basic first aid techniques and cardiopulmonary resuscitation (CPR) methods was available in the facility at all times when a client is present. The findings are: Review on 10/27/20 of Staff #3's personnel record revealed: -date hired was 6/20/18no documentation of First Aid and CPR training. Review on 10/19/20 of Client #1's record revealed: -admitted on 5/8/20 with diagnoses of Major Depressive Disorder, Generalized Anxiety Disorder, and Post-Traumatic Stress Disorderage 16. Review on 10/29/20 of FC #7's record revealed: -admitted on 1/6/20 with Attention Deficit Hyperactivity Disorder, Encounter for mental health services for perpetuator of non-parental child abuseage 17.	V 108	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
AND FLAN OF CORRECTION			A. BUILDING: _			
		MHL012-137	B. WING		C 10/30/2020	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
PARK PLA	ACE	109 PARKE				
1741411 27		MORGANT	ON, NC 28655	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
V 108	Continued From page 2		V 108			
	Review on 10/19/20 of from July 2020 through revealed: -a 7/30/20 Level 1 incuments from July 2020 through revealed: -a 7/30/20 Level 1 incuments from July 4 when I injury that had a First real 8/10/20 Level 1 incuments from July 4 work task. Client #1 sequired a First Aid results of the July 4 work task. Client #1 sequired a First Aid results from July 4 with Client #1 work task.	of facility incident reports gh September 2020 sident for Former Client (FC Staff #3 with a work task at the fell and sustained an Aid response; sident for Client #1 when he tood on his right lower leg that sister facility A with a sustained an injury that seponse.				
	-a red area that was shaped to resemble the number "7" was located below the right knee with a couple of smaller scratches to the left and two red spots near the small scratches; -the right lower leg was injured while Client #1 and Staff #3 attempted to join a piece of furniture together with screws and a piece of the furniture came apart and scraped Client #1's leg, which bled. Client #1 showed the injury to Staff #3, was provided with alcohol wipes and ointment to apply to the leg and kept on working. The injury happened at sister facility A under Staff #3's supervision.					
	-he helped Staff #3 w facility A, where he w supervision; -his fall occurred at si a minor injury.	ster facility A and resulted in				
	-Client #1 and FC #7 at sister facility A;	with Staff #3 revealed: helped him with work tasks and supervision of these				

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STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION ((X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED		
			D MINO		С		
		MHL012-137	B. WING		10/3	0/2020	
NAME OF P	ROVIDER OR SUPPLIER		RESS, CITY, STA	ITE, ZIP CODE			
PARK PLA	ACE	109 PARKE		-			
			ON, NC 2865				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) REGULATORY OR LSC IDENTIFYING INFORMATION) ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CORRECTIVE ACTION SHOULD BE CORRECTIVE ACTION SHOULD BE DEFICIENCY)			(X5) COMPLETE DATE			
V 108	Continued From page 3		V 108				
V 108	clients while they wor A; -he checked FC #7 ar scratch to his leg whin not broken. FC #7 sa reported FC #7's injure he denied knowledge injured at sister facilith he would have known. Interview on 10/28/20 (HM) of sister facility care-taking responsibility care-taking responsibility. Interview on 10/28/20 Director revealed: -Staff #3 was suppose	fter the fall and there was a ch was red, but the skin was id he was okay, and he ry to his supervisor. e of Client #1 having been y A. If Client #1 was injured, a about the incident. O with the Home Manager A revealed: A had no supervisory or oilities to the clients that d FC #7 who helped Staff #3 t sister facility A; e been staff of sister facility 1:30-2:00 pm and the clients ave been preparing to leave	V 108				

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