STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL011-247	A. BUILDING: _____ B. WING _____	C 11/03/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCS	6 BYAS LANE/180 BUCKEYE COVE ROAD SWANNANOA, NC 28778

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 000	INITIAL COMMENTS A complaint survey was completed on November 3, 2020. The complaints were substantiated (Intakes # NC00168861, NC00169728 and NC00169894). Deficiencies were cited. This facility is licensed for the following service categories: 10A NCAC 27G.5400 Day Activity for Individuals of all Disability Groups 10A NCAC 27G.5100 Community Respite Services for Individuals of all Disability Groups	V 000		
V 112	27G .0205 (C-D) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (c) The plan shall be developed based on the assessment, and in partnership with the client or legally responsible person or both, within 30 days of admission for clients who are expected to receive services beyond 30 days. (d) The plan shall include: (1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement; (2) strategies; (3) staff responsible; (4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both; (5) basis for evaluation or assessment of outcome achievement; and (6) written consent or agreement by the client or responsible party, or a written statement by the provider stating why such consent could not be obtained.	V 112		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL011-247	A. BUILDING: _____ B. WING _____	C 11/03/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCS	6 BYAS LANE/180 BUCKEYE COVE ROAD SWANNANOA, NC 28778

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 112	Continued From page 1	V 112		

This Rule is not met as evidenced by:
Based on observation, record reviews and interviews, the facility failed to develop and implement strategies to address the needs and behaviors for two of two clients audited (Clients #1 and #2). The findings are:

Review on 10/16/20 of Client #1's record revealed:
-admitted on 7/16/08.
-diagnoses of Profound Intellectual Developmental Disability, Autism Spectrum Disorder, Seizure Disorder, and Dysphagia.

Review on 10/16/20 of Client #1's most recent assessment dated 5/1/20 revealed:
-he needed one-on-one assistance with toileting and ambulating.

Review on 10/16/20 of Client #1's treatment plan dated 5/1/20 revealed:
-he continued to need one-on-one staff due to his inability to be safe.
-he had behaviors that included hitting, kicking, throwing items, and over turn tables and chairs.
-he was very quick to react and had sudden erratic behaviors and tried to run.

Review on 10/21/20 of facility incident reports from July 2020 - September 2020 for Client #1 revealed:
-8/11/20- client stood up from couch - took one

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL011-247	A. BUILDING: _____ B. WING _____	C 11/03/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCS	6 BYAS LANE/180 BUCKEYE COVE ROAD SWANNANOA, NC 28778

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 112	Continued From page 2	V 112		

step and fell face down on floor.
-he had about a 1-inch cut on the inside and outside of his upper lip.
-taken to emergency room - no treatment was provided.
-comments section - client had been unstable on his feet - he had a "non-fall" to his knees on 8/10/20 and 8/11/20.
-how the incident may be prevented - continue to monitor his gait.

-8/19/20 - a chair was heard moving and when looked the client was seen getting up from the floor.
-the client had a gash in his forehead and was taken to the emergency room where he received 7 stitches.
-how the incident may be prevented - the assigned staff need to stay with the client at all times.

-9/4/20 - the client's hand was noticed to be bleeding - between his left thumb and forefinger.
-it was determined he must have been playing with his gait belt.
-comments section - notified staff to take the client's gait belt off when he was not being assisted with ambulating.

Observation on 10/13/20 at approximately 1:15 p.m. of Client #1 revealed:
-he was in a small classroom sitting on the couch.
-Staff #1 was his one-on-one assigned worker for the day and in the room as well.
-the client's brother and his one-on-one worker were present as well as the Qualified Professional (QP).
-the client looked up when his name was called but he did not respond.
-he had his gait belt on wrapped about his upper

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL011-247	A. BUILDING: _____ B. WING _____	C 11/03/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCS	6 BYAS LANE/180 BUCKEYE COVE ROAD SWANNANOA, NC 28778

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 112	Continued From page 3 chest area. Review on 10/21/20 of a Plan of Action signed by the Director on 8/21/20 for Client #1 revealed: -staff should always have visibility on the client. -two staff should help assist the client when walking. -there were no staff signatures to determine who was provided this information. Review of Clinical Supervision Plans from July 2020 - September 2020 revealed: -Staff #1 - 9/29/20 - Consumer Topics Discussed - Client #1 was not listed. -Staff #2 - 7/30/20 - Consumer Topic Discussed - Client #1 needed closer parking due to trouble walking. -8/27/20 - Consumer Topic Discussed - Client #1 was being stubborn progressing on his goals. Review on 10/21/20 of Client Specific Competencies for Client #1 with an effective date of 5/1/20 revealed: -behavior concerns - "Very quick to react and makes split decisions and actions. Throw things, over turn tables and chairs and property destruction...daily care...required total assistance in bathroom..." -Staff #1 signed 4/22/20. -Staff #2 signed 4/24/20. -Staff #3 signed 4/28/20. -Staff #4 signed 4/21/20. Review on 10/29/20 of an In-Service/Staff Meeting dated 10/21/20 revealed: -gait belt training was covered as an agenda item. -Staff #1, #2 and #3 signed as being present. Interviews on 10/22/20 and 10/29/20 with Staff #1	V 112		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL011-247	A. BUILDING: _____ B. WING _____	C 11/03/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCS	6 BYAS LANE/180 BUCKEYE COVE ROAD SWANNANOA, NC 28778

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 112	Continued From page 4 revealed: -she had worked with Client #1 once or twice in the past 2 months. -she was aware the client required one-on-one assistance which meant to keep eyes on him at all times. -she was not present during either of the falls. -she was his one-on-one worker on 9/4/20 when his hand was bleeding. -only thing she could guess that it was caused by him playing with the end of his gait belt. -she actually didn't see the injury until after the fact. -she was aware the gait belt was not to be kept on all day. -she learned of client needs in "Supervision", she was told verbally client had fallen and two people were needed to ambulate him. Interviews on 10/22/20 and 10/29/20 with Staff #2 revealed: -she had been assigned Client #1's one-on-one worker since his last fall on 8/19/20. -she was present in the room during both falls on 8/11/20 and 8/19/20 as she was the one-on-one for his brother. -the first fall his one-on-one worker was in the room as well - but on the other side preparing his lunch. -the second fall his one-on-one worker left the room and she heard the client fall and called for help. -she was told he was a fall risk and that a gait belt was needed to assist him in ambulating. -she learned of changes in his needs verbally. -she was told to take off the client's gait belt when not assisting to ambulate him. -she was never told to use two staff when ambulating him.	V 112		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL011-247	A. BUILDING: _____ B. WING _____	C 11/03/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCS	6 BYAS LANE/180 BUCKEYE COVE ROAD SWANNANOA, NC 28778

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 112	Continued From page 5 Interviews on 10/22/20 and 10/29/20 with Staff #3 revealed: -she usually found out about changes to client's needs verbally. -we noticed Client #1's gait was getting "really bad." -they applied the gait belt after his first fall on 8/11/20; she was not sure if he had the gait belt on while in the classroom. -she did not remember being told he needed two people to assist with ambulating. Interview on 10/29/20 with Staff #4 revealed: -he was aware Client #1 was at risk for falling and had not worked with the client since the 8/19/20 fall. -he did not remember using a gait belt when he worked with Client #1. -his ability to walk changed day-to-day; sometimes he would seem drowsy and off balance more than other days. -he remembered being told that someone needed to help ambulate Client #1 when he was unstable. Review on 10/21/20 of Client #2's record revealed: -admitted on 6/18/20. -diagnoses of Obsessive Compulsive Disorder, Bipolar Disorder, Psychotic Disorder, Mild Intellectual Developmental Disability, Neuroleptic, Tardive Dyskinesia, Obesity, Impulse Disorder Not Otherwise Specified, Anxiety Disorder, and Gastroesophageal Reflux Disease. Review on 10/21/20 of Client #2's assessment dated 10/24/19 revealed: -she had a history of going to Physical Therapy from falling. -she caused self-injury by hitting self on her head. -her behaviors included verbal escalation, yelling	V 112		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL011-247	A. BUILDING: _____ B. WING _____	C 11/03/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCS	6 BYAS LANE/180 BUCKEYE COVE ROAD SWANNANOA, NC 28778

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 112	Continued From page 6	V 112		

and obsessing loudly, and non-stop talking.
-she had auditory hallucinations and needed "intense redirection."
-she walked with her head down and incessant self-talk interfered with performing all Activities of Daily Living.

Review on 10/21/20 of Client #2's Plan of Care dated 12/1/19 revealed:
-she was ambulatory but must use a walker due to poor balance.
-at risk of falling if she stands too long.
-she must not bend over to pick up objects as she will lose her balance and may fall.
-she required constant prompting to pay attention and not talk while ambulating.
-"...She can't move and talk at the same time. She talks incessantly."

Review on 10/21/20 of Client #2's treatment plan dated 6/12/20 revealed:
-continue to observe "...personal health and safety awareness by requesting staff assistance with tasks that could put her at risk of injury (falling)...practice safety when walking by looking to avoid obstacles, changes in terrain, and refrain from talking so she will be able to decrease falls."

Review on 10/21/20 of facility incident reports from July 2020 - September 2020 for Client #2 revealed:
-8/11/20 - client fell going down the ramp in the back parking lot.
-her walker went ahead of her while going down the ramp; she had a small scrape on her knee.
-how the incident may be prevented - client needs to be kept close to her walker and use a different way to go outside the building.
-comments - will use a different door to exit and have the car closer to the door.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL011-247	A. BUILDING: _____ B. WING _____	C 11/03/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCS	6 BYAS LANE/180 BUCKEYE COVE ROAD SWANNANOA, NC 28778

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 112	Continued From page 7 -8/14/20 - client fell outside the back door as she was walking to the car. -she was shuffling her feet as she walked and then pushed her walker out in front of her. -she had a scrape on her elbow and her knee. -how the incident may be prevented - to shorten the distance and have her walk on a flat surface - take her out the front entrance. -staff will be informed and management will monitor. -8/18/20 - client sitting in chair and leaned over to get a cracker she dropped and fell out of the chair. -how the incident may be prevented - staff can monitor her behavior. -8/20/20 - client was walking through classroom - she pushed her walker in front of her and fell on her right side. the client was obsessing about coloring - staff asked her to wait. -how the incident may have been prevented - continue to monitor behaviors and attempt to deter them for happening. -comments - Client was taken to the emergency room, has a broken hip and will need to have surgery. Review of Clinical Supervision Plans from July 2020 - September 2020 revealed: -Staff #3 - 7/30/20 - Planned Performance Objectives - staff will learn about Client #2. Review on 10/21/20 of Client Specific Competencies for Client #2 with an effective date of 6/15//20 revealed: -behavior concerns - "Behavior plan in place to redirect from behaviors of concern...Medical Concerns - Often makes quick moves that are	V 112		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL011-247	A. BUILDING: _____ B. WING _____	C 11/03/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCS	6 BYAS LANE/180 BUCKEYE COVE ROAD SWANNANOA, NC 28778

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 112	Continued From page 8	V 112		

unsafe and needs reminders to utilize walker..."
-Staff #1 signed 6/18/20.
-Staff #2 signed 6/25/20.
-Staff #3 signed 6/18/20.
-Staff #4 signed 7/1/20.

Interview on 10/29/20 with Staff #1 revealed:
-she was providing assistance when Client #2 fell on 8/11/20 and 8/14/20.
-during both falls the client pushed her walker out in front of her and fell.
-both falls occurred while going out the back door as she was going down the ramp.
-she did not remember being told not to take Client #2 out the back door until after the second fall.
-she was aware the client had attention-seeking type of behaviors but did not know to what extent.
-she was told about de-escalation strategies - but could not remember what they were now.

Interviews on 10/22/20 and 10/29/20 with Staff #3 revealed:
-she was present during all of Client #2's falls.
-after the first fall we tried to make sure someone was right beside her as she walked.
-she would push her walker out in front of her instead of walking up to it.
-sometimes she found out what a client's needs were when she was given a "Hot Sheet" which gave a snap shot of the individual.
-she remembered being given a "Hot Sheet" for Client #2 and was told "she was pretty good" at her previous day care center.
-there may have been a misunderstanding on which door to take her out when leaving the building.
-she believed she was told after the second fall to take the client out a different door.
-the QP and the Director will go over "Client

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL011-247	A. BUILDING: _____ B. WING _____	C 11/03/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCS	6 BYAS LANE/180 BUCKEYE COVE ROAD SWANNANOA, NC 28778

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 112	Continued From page 9	V 112		

Specifics" with her - we don't always get all the information.
-she was told Client #2 had some yelling, but not to the extent we experienced.
-usually if a client had changes in their needs they were verbally notified by the QP or Director.

Interview on 10/29/20 with Staff #4 revealed:
-he was not present during any of the client's falls, but he remembered being told verbally she had a lot of falls.
-he remembered being told verbally to not take Client #2 out the back door because of the ramp.
-Client #2 had never fallen when he transported her.

Interview on 10/23/20 with the QP revealed:
-he noticed the gait belt was on Client #1 during observation on 10/13/20.
-the gait belt should not have been on the client - he had not had a chance to say anything to staff.
-when asked how Client #1 was able to rub his hand raw with the gait belt on 9/4/20 - he replied "that was a good question."
-the staff should have intervened earlier - they probably did not think it was going to cause a sore.
-Client #2 - the measures put in place after her first fall on 8/11/20 were general type of re-directions - i.e. be closer to her when ambulating, be aware of when she was upset, remind her to pick up her feet, and remind her to keep her walker closer to her.
-he or the Director would go over "Client Specifics" to inform staff of client's needs.

Interviews on 10/27/20 and 10/30/20 with the Director revealed:
-he or the QP would notify staff what the clients' needs were prior to coming to the day program.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL011-247	A. BUILDING: _____ B. WING _____	C 11/03/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCS	6 BYAS LANE/180 BUCKEYE COVE ROAD SWANNANOA, NC 28778

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 112	Continued From page 10 -he did this via "Supervisions" or by going over "Client Specifics." -Client #1 falling was something new - he had never fallen in the past. -he verbally told the one-on-one staff that they should always have visibility on the client, to use a gait belt when ambulating him and take it off when not ambulating him, and that two people should assist him when ambulating. -Client #2 was new to the program as of June 2020. -they went over with staff about her attention seeking behaviors and that she had a tendency to fall. -after the first fall he told staff verbally to not take her out the back door since she fell the first time going down the ramp. -after Client #1 and Client #2 fell there were no treatment team meetings held to discuss updating the plan with new/different strategies to help prevent falls. Review on 10/30/20 and 11/02/20 of a Plan of Protection dated 10/30/20 and 11/2/20 signed by the Director revealed: "What immediate action will the facility take to ensure the safety of the consumers in your care? A. After [Client #1's], I have created my own Plan of Action on 8/21/20. 1) Staff should always have visibility on their own members. 2) Staff needs to find someone to cover their member before leaving for any reason. 3) If staff cannot find anyone to cover for them, they should contact their supervisor for coverage. 4) Using two staff to walk with [Client #1] while he is walking unless the team agrees that one person is sufficient while utilizing a gait belt. 5) Training with all staff the importance of having visual sight on their 1:1. 6) Disciplinary action will be made if failure to	V 112		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL011-247	A. BUILDING: _____ B. WING _____	C 11/03/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCS	6 BYAS LANE/180 BUCKEYE COVE ROAD SWANNANOA, NC 28778

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 112	Continued From page 11 follow safety procedures. B. Any new information regarding the health or safety of the member will be written on a client specific signed by the staff to ensure clear communication. C. If [Client #2] return back to LINCS, a plan meeting will be put in place to go over the importance of how to provide the best quality of care for the benefit of her health and safety. Describe your plans to make sure the above happened. A. 1) Supervisors, [Director and QP], will take time out of their day to walk around the facility every day to ensure that every staff has visibility on their own members. 2 and 3) Supervisors, [Director and/or QP], will monitor and go over in supervision with staff about covering their member before leaving and if the staff does not have coverage to contact their supervisor. This training will be completed by November 20th, 2020. 4) Supervisors, [Director and/or QP], will monitor and indicate on the client specific about the new information about having two staff walking with [Client #1] while he is walking and update it if the team agrees with just having one staff walk with him while utilizing a gait belt. Update client specifics will be completed by November 6th, 2020. Gait Belt training trained for all staff was completed during LINCS staff Meeting on October, 21st, 2020 and also went over during each staff supervision that was completed by October 30th, 2020. 5) Training with the staff regarding having visual sight on their 1:1 will be recorded on their supervision. This training will be covered in their supervision will be completed by November 20th, 2020. 6) Supervisors, [Director and/or QP], will monitor for safety and health of the member and if they see	V 112		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL011-247	A. BUILDING: _____ B. WING _____	C 11/03/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCS	6 BYAS LANE/180 BUCKEYE COVE ROAD SWANNANOA, NC 28778

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 112	Continued From page 12	V 112		

an issue, disciplinary action or necessary training will be made. This will be discussed with the staff on their Supervision which will be completed by November 20th, 2020.
B. Any new information regarding the health and safety of the member will be updated on the client specific by the supervisor and reviewed and signed by the supervisor and staff for effective communication. This process is starting now, November 2nd, 2020 and will be an ongoing procedure.

C. If [Client #2] team agrees to have her return to LINCS, a team meeting will be addressed and have a discussion on her behaviors, on her safety needs, and on her health needs. Supervisors, [Director and/or QP] will update [Client #2] client specifics regarding exiting out of the front, recognizing her behaviors, and having a staff help her while moving which will be completed by November 6th, 2020."

Clients #1 and #2 attended this day activity program Monday through Friday for clients whose primary diagnosis was Intellectual Development Disability. Client #1 had a one-on-one worker in place due to his inability to be safe. He had increased instability and required use of a gait belt. He had two falls within 8 days while staff were not with him. On the second fall he suffered injury to his head which required 7 stitches. Client #1 also had a separate injury resulting from repeatedly rubbing his hand on his gait belt, causing bleeding between his first finger and thumb. His one-on-one worker did not see the injury until after the fact. Measures to prevent this situation from recurring were conveyed to the staff verbally. Upon interviewing the staff they were not consistent in what they were told regarding the changes put in place after Client

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL011-247	A. BUILDING: _____ B. WING _____	C 11/03/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCS	6 BYAS LANE/180 BUCKEYE COVE ROAD SWANNANOA, NC 28778

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 112	Continued From page 13 #1's falls and injury. Client #2 had a history of falls and fell four times in one month. Her last fall resulted in a fractured hip that required surgery. Staff were told verbally to not take the client out the back door where the ramp was after she fell there the first time. Staff took her out the same back door when she fell the second time. Staff were not aware of the extent of the client's behaviors of yelling and using the walker inappropriately when she was angry until they experienced it. No strategies were updated to address the extent of the client's behavior. The facilty used "Supervisions" and "Client Specifics" to communicate with staff about the clients needs, however they were not updated after Client #1 and Client #2 started having falls. The treatment plans were not updated to reflect the changes in their needs and strategies to help prevent future falls and injuries. There was no documentation to indicate when specific training was done. This deficiency constitutes a Type A1 rule violation for serious neglect and must be corrected within 23 days. An administrative penalty of $1,500 will be imposed for each day the facility is out of compliance beyond the 23rd day.	V 112		