Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND FLAN	OF CORRECTION	IDENTIFICATION NOWBER.	A. BUILDING:		GOIVII LETED	
		MHL063-091	B. WING	B. WING		
NAME OF PI	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE, ZIP CODE	12/04/2020	
			LETON STREET			
MIDDLETO	ON STREET	ROBBINS,	NC 27325			
(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 COMPLI	ETE
V 000	INITIAL COMMENTS		V 000			
	A complaint and follow on December 4, 2020 substantiated (intake Deficiencies cited.					
	This facility is licensed for the following service category: 10A NCAC 27G. 5600C Supervised Living for Adults with Developmental Disabilities					
V 110	27G .0204 Training/S Paraprofessionals	upervision	V 110			
	Paraprofessionals 10A NCAC 27G .0204 COMPETENCIES AND SUPERVISION OF PARAPROFESSIONALS (a) There shall be no privileging requirements for paraprofessionals. (b) Paraprofessionals shall be supervised by an associate professional or by a qualified professional as specified in Rule .0104 of this Subchapter. (c) Paraprofessionals shall demonstrate knowledge, skills and abilities required by the population served. (d) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence. (e) Competence shall be demonstrated by exhibiting core skills including: (1) technical knowledge; (2) cultural awareness; (3) analytical skills; (4) decision-making; (5) interpersonal skills; (6) communication skills; and (7) clinical skills. (f) The governing body for each facility shall					

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

TITLE (X6) DATE

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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	
			5 14/11/0		R-C	
		MHL063-091	B. WING		12/04/2020	
NAME OF D	DOVIDED OD CUDDUED	CTDEET A	DDDECC CITY CTA	TE 710 000E		
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STA			
MIDDI FT	ON STREET	340 MIDI	DLETON STREET	Γ		
	J	ROBBIN	S, NC 27325			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N (X5)	
PRÉFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE COMPLETE	
TAG	REGULATORY OR I	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	RIATE DATE	
				DEFICIENCY)		
V 110	Continued From page	<u>.</u> 1	V 110			
	Continued From page	, I				
	for the initiation of the	individualized supervision				
	plan upon hiring each	paraprofessional.				
	This Rule is not met					
		ews and interviews two of				
	two audited staff (#5					
	demonstrate decision	-making skills required by				
	the population served	affecting Client (#1). The				
	findings are:	, ,				
	3					
	Review on 12/4/20 of	Staff #5 personnel record				
	revealed:	otali no personilei record				
	-Hire date of 10/21/19					
	-Developmental Spec					
	-Completed the follow					
	_ · · · · · · · · · · · · · · · · · · ·	Competency - 4/23/20.				
		Recertification - 5/13/20.				
	-Individual Rights					
	-Overview of Dev	/elopment Disabilities -				
	10/29/19.					
	-Attended Getting It F	Right Inservice on 2/11/20.				
	Review on 12/4/20 of	Staff #6 personnel record				
	revealed:					
	-Hire date of 8/28/17.					
	-Developmental Spec	ialist Sleepover.				
	-Completed the follow					
		Competency - 6/2/20.				
		Recertification - 2/25/20.				
	-Individual Rights					
		/elopment Disabilities -				
	5/15/20.					
	-Attended Getting It ri	ght Inservice on 2/11/20.				

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Division of	of Health Service Regu	ılation			
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
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		MHL063-091	B. WING		12/04/2020
		WII 12003-03 I			12/04/2020
NAME OF PR	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE	
MIDDI ET	0N 0TDEET	340 MIDI	DLETON STREET	Т	
MIDDLETO	ON STREET	ROBBIN	S, NC 27325		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI	
IAG		100 IDENTIFICATION OF THE STATE	TAG	DEFICIENCY)	MAIL
1/ // 2	, <u>-</u>		1,,,,,		
V 110	Continued From page	e 2	V 110		
	Interview on 12/1/20	with Staff #5 revealed:			
	-She worked at the gr	roup home since August			
	2019.				
		it worked at the home			
	full-time.				
		d alternative days with staff			
	#6.				
	-They were sleepover				
		1 to dress himself but			
	needed help.				
	· ·	his shoes on the wrong foot			
	and clothes would be				
	-She made sure he w	vas gresseg well. hoes was on the right foot			
	I	noes was on the right loot he right way on her shift.			
	alla ciotiles was cirti	le light way on her sint.			
	Interview on 12/3/20	with Staff #6 revealed:			
	-She worked at the fir	rst time in 2004 and returned			
	2017.				
	·	ys throughout the week.			
		or four or sometimes five			
	days throughout the v				
		uty client #1 dressed himself.			
		shower, put his shoes on			
	right and lotion client				
	-Then client #1 would	out client #1 shirt on inside			
	out.	out client #1 Stillt on Inside			
		#1 and made sure client #1's			
	clothing was on right.				
		nt #1's shoes were on the			
	right foot.	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			
		nt was completely dressed.			
	-On her shift, she ma				
	looking good and sme				
	-They had a floater th				
	-The floater was staff	#5.			
	-She was only the full	l-time regular staff at the			

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group home.

-Staff #5 was working since she became full-time

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DIVISION 0	t Health Service Regu	lation	_			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COMPLETED		
					R-C	
		MIII 063 004	B. WING		1	
		MHL063-091			12/0	4/2020
NAME OF PF	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		340 MIDD	LETON STREE	т		
MIDDLEIC	ON STREET	ROBBINS	, NC 27325			
(V4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE
TAG	REGULATORY OR I	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE	RIATE	DATE
				DEFICIENCY)		
V 110	Continued From page	3	V 110			
	at the beginning of the					
	-Staff #5 was still a fu					
		nift, she made sure client #1				
	was dressed properly					
		ason client #1 was reportedly				
	~	the wrong foot and shirt				
	inside out.					
	-She reported it did no	ot happen on her shift.				
	It:	1 40/0/00				
	Interview on 12/2/20					
	Residential Manager					
		red with both staff #5 and				
	staff #6 working at the	•				
	-When the day progra					
		ould come into the home				
	and provide services.					
		rker reported client #1 shoe				
	was on the wrong foo					
		f may have noticed the				
	hygiene before staff o	excuse from staff #5 and				
	staff #6.	excuse from stall #5 and				
		alternated days throughout				
	the week.	alternated days throughout				
		complaint about client #1's				
	clothing.	Complaint about clicit #13				
		as back in February 2020				
	from the day program					
	, . ·	aware of the complaint.				
		e with staff #5 and staff #6				
	after the complaint in					
		nt was back in October or				
		gram staff working in the				
	home.	gram own working in the				
		bout client #1 shoes on the				
	wrong foot and shirt o					
		d staff #6 a verbal warning.				
	_	ngs with staff monthly.				

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staff over the phone.

-When she received the complaint, she called the

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:			
	MHL063-091		B. WING			R-C 2/04/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	E, ZIP CODE		
MIDDLET	ON STREET		DLETON STREET IS, NC 27325			
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
V 110	-She also called staff -She did not docume -She went to the grou 3-4 days throughout of -She was not at the good left for the day progration in the second staff of the day programThere was no disciplether was no disciplether was no disciplether was no staff of the day in the second staff of the second	Ithat was off that day. Int the verbal warning. Ithat was off that day. Ithat was off that day. Ithat week. Ithat	V 110			
V 540	and not paying attent -Confirmed Staff #5 a staff working at the gi 27F .0103 Client Right Grooming 10A NCAC 27F .0103 AND GROOMING (a) Each client shall dignity, privacy and h of personal health, hy Such rights shall inclu to the:	and Staff #6 were the only roup home. hts - Health, Hygiene And	V 540			

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		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	CORRECTION IDENTIFICATION NUMBER: A. BUILDING:			COMPLETED	
					R-C	
		MHL063-091	B. WING		12/04/2020	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE		
		340 MIDE	LETON STREE	г		
MIDDLETO	ON STREET	ROBBINS	S, NC 27325			
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE	
				,		
V 540	(3) opportunity barber or a beauticiar (4) provision of paper and soap for earlindividual personal hy indigent client. Such cont limited to toothpas napkins, tampons, shutensil. (b) Bathtubs or show individual privacy sha	to shave at least daily; to obtain the services of a n; and linens and towels, toilet ach client and other rgiene articles for each other articles include but are ste, toothbrush, sanitary aving cream and shaving ers and toilets which ensure Il be available. lavatory and bath facilities client with a mobility	V 540			
	This Rule is not met as evidenced by: Based on observation and interviews, the facility failed to ensure the right to dignity, privacy and humane care in the provision of personal health, hygiene and grooming was implemented affecting one of three audited clients (#1). The findings are: Review on 12/1/20 of Client #1's record revealed: -Admission date of 5/3/10Diagnoses of Intellectual Development Disability, Severe, Major Depressive Disorder, Urinary Incontinence, Diabetes Type II Mellitus, Seizure Disorder by History, Generalized Epilepsy and Non-VerbalTreatment Plan dated 11/1/20 revealed the following goal: - "[client #1] will receive assistance with appropriately completing bathing and grooming." -Treatment Plan dated 11/1/20 - "Supports Needed to Complete Activities of Daily Living revealed:					

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		MHL063-091	B. WING		R-C 12/04/2020	
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STA	TE, ZIP CODE		
MIDDI ET	ON STREET	340 MIDE	DLETON STREET	г		
MIDDLEI	ON STREET	ROBBINS	S, NC 27325			
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE	
V 540	Continued From page	e 6	V 540			
	grooming."					
	REGULATORY OR LSC IDENTIFYING INFORMATION) 40 Continued From page 6					
	days throughout the v	r four or sometimes five veek. ity client #1 dressed himself.				

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PRINTED: 12/07/2020

Division o	of Health Service Regu	lation			FORM	IAPPROVED
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		MHL063-091	B. WING		R-C 12/04/2020	
NAME OF PR	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
			DLETON STREET			
MIDDLETO	ON STREET	ROBBIN	S, NC 27325			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	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	(X5) COMPLETE DATE
V 540	Continued From page	÷ 7	V 540			
	-She gave client #1 a right and lotion client: -Then client #1 would -Previously would take programTransportation was powenShe had no idea abooutShe assisted client # clothing was on rightShe made sure client right footShe made sure client: -The residential manato her attentionOn her shift, she made looking good and smeethey had a floater the The floater was staffShe was only the full group homeStaff #5 was working at the beginning of the Staff #5 was still a furwhen she was on she was dressed properly -Client #1 had a one-of the house prior to client programReported if client #1 was not on her shiftShe did not know real	shower, put his shoes on #1 down. go the day program. e client #1 to the day provided by the company put client #1 shirt on inside 1 and made sure client #1's t #1's shoes were on the t was completely dressed. The ager brought the complaint de sure client #1 was the selling good. The ager brought the selling good. The ager brought staff at the since she became full-time the year. The since she became for the year. The since she year.				
	wearing his shoes on inside out.	the wrong foot and shirt				

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-She reported it did not happen on her shift.

Interview on 12/2/20 and 12/3/20 with the

-She became the residential manager January

Residential Manager revealed:

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Division of	<u>of Health Service Regu</u>	lation				
		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN C	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COMPLETED	
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			B. WING			
		MHL063-091	B. WING		12/04	/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
		340 MIDI	DLETON STREE	т Т		
MIDDLET	ON STREET		S, NC 27325	•		
			5, NC 27325	T		
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	I	(X5) COMPLETE
PREFIX TAG		LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPR		DATE
		,	,,,,,	DEFICIENCY)		
V 540	Continued From page	e 8	V 540			
	2020.					
		red with both staff #5 and				
	staff #6 working at the					
	-When the day progra					
		ould come into the home				
	and provide services.					
		rker reported client #1 shoe				
	was on the wrong foo					
		e clients are as independent				
	as possible.					
		f may have noticed the				
	hygiene before staff o					
	-There was no valid e staff #6.	excuse from staff #5 and				
	-There was normally a until covid.	3 staff working at the home				
		alternated days throughout				
	the week.	alternated days throughout				
		complaint about client #1's				
	clothing.	complaint about offering 110				
	•	as back in February 2020				
	from the day program	•				
		aware of the complaint.				
		e with staff #5 and staff #6				
	after the complaint in					
	=	nt was back in October or				
		gram staff working in the				
	home.	0				
		bout client #1 shoes on the				
	wrong foot and shirt o					
	•	id staff #6 a verbal warning.				
		ngs with staff monthly.				
		he complaint, she called the				
	staff over the phone.	, ,				
	-She called staff that	was off that day.				
	-She did not documer					
		· ·				
	-She went to the group home every week; about 3-4 days throughout the week.					

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left for the day program.

-She was not at the group home when client #1

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Division o	of Health Service Regu	liation				
STATEMENT OF DEFICIENCIES (X1		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COMPLETED		
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					R-	
		MHL063-091	B. WING		12/0	4/2020
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NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	II E, ZIP CODE		
MIDDI ETO	ON STREET	340 MIDD	LETON STREE	Т		
WIIDDELIN	JN STREET	ROBBINS	, NC 27325			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	V	(X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE	RIATE	DATE
				DEFICIENCY)	l	
V/ E40	0 " 15	•	1/540			
V 540	Continued From page	9	V 540			
	-She was at the home	e when client #1 returned.			ļ	
		as adjusted at the day			ļ	
	_	to dajaotoa at tho day			ļ	
	program.	linam, actions			ļ	
	-There was no discipl				ļ	
		rts regarding client #1's body			ļ	
	odor.				ļ	
		in the morning and a 2nd if			ļ	
	client #1 had an accid	dent but wasn't often.			ļ	
	-She made unannour	nced visits at the group			ļ	
	home on the weeken	ds.			ļ	
	-The other clients wer	re independent.				
	-Client #1 was non-ve	erbal.			ļ	
	-Client #1 would get u	up in the morning and take a			ļ	
	shower and put on his					
	•	I staff #6 to put client #1's				
	clothing out.	retuin #6 to part short # 1 c			ļ	
	•	was made aware to check			ļ	
					ļ	
	client #1 before leavir	ng the house.				
	Interview on 12/4/20	with the Qualified				
	Professional revealed	d:			ļ	
	-He was aware of the	two separate complaints.			ļ	
		complaint in February and			ļ	
	the complaint made b	,			ļ	
	•	a staff meeting and trained				
	on this before.	a cian meening and names			ļ	
		ding that staff #5 and staff			ļ	
		~			ļ	
	#6 understood and w	•			ļ	
	 -He realized staff #5 and staff #6 did not understand because after receiving another complaint. 				ļ	
					ļ	
					ļ	
	_	nth to discuss everything			ļ	
	was going on in the h	iouse.			ļ	
	-Issues would also be	e addressed before staff				
	meeting as needed.					
		#5 and staff #6 on a daily				
	basis as needed.	,				
			1			1

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