Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		A. BUILDING: _			
		MHL001-259	B. WING		R <b>05/27/2021</b>
NAME OF PR	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
A MOTHE	P'S I OVE	1227 WEST	MORLAND DI	RIVE	
AWOTTE	(3 LOVL	BURLINGT	ON, NC 27215	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 000	INITIAL COMMENTS		V 000		
	completed on May 27 (intake #NC00176347 Deficiencies cited. This facility is licensed category: 10A NCAC	d for the following service			
V 112	27G .0205 (C-D) Assessment/Treatme  10A NCAC 27G .0205 TREATMENT/HABILI PLAN		V 112		
	(c) The plan shall be assessment, and in p legally responsible pe of admission for clien receive services beyon (d) The plan shall income	clude: ) that are anticipated to be n of the service and a			
	<ul> <li>(2) strategies;</li> <li>(3) staff responsible;</li> <li>(4) a schedule for re annually in consultation responsible person of</li> <li>(5) basis for evaluation outcome achievement</li> <li>(6) written consent of responsible party, or an achievement</li> </ul>	; view of the plan at least on with the client or legally r both; on or assessment of			

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Division of	of Health Service Regu	lation					
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	A. BUILDING:		ETED	
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		MHL001-259	B. WING		1	7/2021	
					1 00/2	172021	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STA	TE, ZIP CODE			
A MOTHE	R'S I OVE	1227 WE	STMORLAND D	RIVE			
AMOTTIE	KOLOVL	BURLING	STON, NC 2721	5			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX		Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE		COMPLETE DATE	
TAG	REGULATORT OR E	SO IDENTIFY TING INFORMATION)	TAG	DEFICIENCY)	MAIL	57.1.2	
V 112	Continued From page	: 1	V 112				
	This Rule is not met	as evidenced by:					
		and record review, the					
	facility failed to (a) co	mplete an admission					
	assessement for one	of three audited clients (#1);					
	and (b) include and in	mplement strategies to					
	address clients ability	to earn money affecting two					
	of three audited client	s (#1 and #2). The findings					
	are:						
	(a)Review on 5/25/21	of Client #1's record					
	revealed:						
	-Age 13.	100 100					
	-Admission date of 11						
	Attention Deficit Hype	cified Depressive Disorder,					
		on and Unspecified Anxiety					
	Disorder.	on and onspecified Anxiety					
		sment completed by the					
	facility in client's reco						
,,							
	Interview on 5/27/21 v	with the Director/Qualified					
	Professional #3 revea	iled:					
	-She was responsible	for completing client's initial					
	assessment.						
		was no facility assessment					
	in client #1's record.						
	(b)Review on 5/25/21	of Client #1's record					
	revealed:						
	-Age 13.	100 100					
	-Admission date of 11						
		cified Depressive Disorder,					
	Attention Deficit Hype	eractivity Disorder,					

Disorder.

Combined Presentation and Unspecified Anxiety

STATE FORM 6899 AEDC11 If continuation sheet 2 of 19

Division of Health Set	vice Regi	ulation					
STATEMENT OF DEFICIENC		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION	١	IDENTIFICATION NUMBER:	A. BUILDING:	A. BUILDING:		COMPLETED	
				_			
		D WING		F			
MHL001-259			B. WING		05/2	7/2021	
NAME OF PROVIDER OR SU	IDDI IED	STREET A	DDRESS, CITY, STA	ATE ZIR CODE			
NAME OF TROVIDER OR SO	n i LiLix						
A MOTHER'S LOVE			STMORLAND D				
		BURLING	STON, NC 2721	5			
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PREFIX (EACI		CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE	
TAG REGU	LATORY OR	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	RIATE	DATE	
				DEI ICIENCI)			
V 112 Continued	From page	e 2	V 112				
Continuou	r rom pag	0.2					
-Treatment	Plan com	pleted 1/5/21 included the					
following go	oals:						
-I want	to stay fo	ocused, "I want to be able to					
		better decisions for myself.					
		ve my overall mood - over the					
		vill demonstrate progress with					
		Il mood and how she feels					
		ners by learning to use					
		lers by learning to use					
coping skill		and the same of th					
		on my attitude and not go off					
	-	make me mad. Client will					
		ge appropriate responses					
	•	et her way or is told no.					
Client will le	earn and ເ	utilize "I" statements and					
other positi	ve commu	unication skills to verbalize					
and proces	s all emot	tions as need.					
Review on	5/25/21 of	f Client #2's record revealed:					
-Age 16.							
-Admission	date of 1	0/24/18.					
		sitional Defiant Disorder,					
		sorder, Attention Deficit					
		er, Combined Presentation.					
		ppleted 10/18/20 included the					
following goals:							
0.0	-Client will use social and coping skills that						
		. •					
	-	conflicts with peer relations					
-Client will follow directives in the home, school and community settings.							
school and	communi	ty settings.					
		with Client #1 revealed:					
-She denie	d going to	the Program Coordinator's					
home.							
-Staff took	them out t	to eat, to the park and drove					
around.							
-Denied ao	ing to clea	an staff home.					
		st she went to the Program					
Coordinato	-						

Division of Health Service Regulation

paid her \$15.00.

-She told the therapist the Program Coordinator

STATE FORM 6899 AEDC11 If continuation sheet 3 of 19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:	(X3) DATE SURVEY COMPLETED			
	MHL001-259	B. WING	R <b>05/27/2021</b>			
NAME OF PROVIDER OR GURBLIER						

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

# 1227 WESTMORLAND DRIVE

A MOTHE	P'S LOVE	227 WESTMORLAND DRIVE			
AMOTTIE	BI	URLINGTON, NC 27215			
(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	V 112			
V 112	-She said it didn't happen. She stated, "I have a weird imagination."  - "I just pretend things happen when they did not she stated, "I now know it would get people in trouble."  -She mentioned she imagine her barbie doll broke her leg.  -She talked to her doll.  -She could not describe what the Program Coordinator's home looked like.  - "I don't know, it was just an imagination."  Interview on 5/25/21 with Client #2 revealed:  -She confirmed she went to the Program Coordinator's home to help clean.  - "It was like volunteer work to get her out the house and bond with staff."  - "I like to clean."  -She helped pick up a couple of things in the house.  -She swept the floor.  -The program coordinator was also helping and cleaning with her.  -The program coordinator would reward her with something to eat, cash and clothes.  -The program coordinator would get us things weeded.  -She went to the program coordinator's home a couple of times.  -She did not go to the house for a couple of months.  -She told her guardian and said the guardian did not have a problem with it.  Interview on 5/26/21 with Client #1's Guardian revealed:  -She became client #1's social worker and guardian in February 2020.  -Client #1's therapist informed her that she wen	h ve			
Division of He	to the program coordinator's home.  alth Service Regulation				

STATE FORM 6899 If continuation sheet 4 of 19 AEDC11

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:	(X3) DATE SURVEY COMPLETED				
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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							

# 1227 WESTMODI AND DDIVE

I A MOTHER'S LOVE		227 WESTMORLAND DRIVE			
		RLINGTON, NC 27215			
(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	V 112			
	Continued From page 4  -She was not aware of the incident prior to client #1 going to staff's houseShe had a conversation with the Director/Qualified Professional #4 on April 13, 2021The conversation with the Director/QP #4 occurred after the incidentThe group home tried to find creative ways to allow client #1 to earn an allowanceThe incident occurred once and some months agoShe did not know the exact date of the incidentShe thought it was unethical practicesShe was informed it was not happening anymore.  Interview on 5/26/21 with Client #2's Guardian revealed: -She became client #2's guardian over one yearThe judge approved home study for client #2 to go the Director/QP #4's home for a weekendIt was being arranged the Director/QP #4 would be client #2's guardianClient #2 would go over on the weekends and understand that it would be a different roleThat owner would be a parental figureShe was not aware client #2 was going to the program coordinator's home to do choresThis would have to go through the judgeShe was not aware client #2 went to the program coordinator home to earn moneyShe knew client #2 had been wanting to earn moneyNo one asked her about it or told her about itAs an incentive the group home would compensate the clients for going over and beyondIf the group home had presented idea to her she would have included it in the home study.	n			

Division of Health Service Regulation

STATE FORM 6899 AEDC11 If continuation sheet 5 of 19

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:	(X3) DATE SURVEY COMPLETED
		MHL001-259	B. WING	R <b>05/27/2021</b>
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

# 1227 WESTMORLAND DRIVE

(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COM	A MOTHE	R'S LOVE	V WESTMORLAND DRIVE LLINGTON, NC 27215			
Interview on 5/25/21 with the Program Coordinator revealed: -She worked 1st shift from 7:00 a.m 3 p.mShe admitted to taking client #1 and client #2 to her home on different occasionsShe reported she wanted to give clients the ability to earn moneyClient #1 cleaned her home 1 time and client #2 about 3 timesClient's would sprinkle carpet fresh on the carpet and vacuum, swept the kitchen floor, dust and took out recycle garbage "It was nothing more that client #1 and client #2 didShe provided opportunity to let clients earn cashThe clients were at her home about 1 ½ or 2 hours when they were thereShe paid client #1 and client #2 \$15.00 and provided lunchShe reported client #1 and client #2 agreedConfirmed she did not get approval from the guardiansClient #1's guardian learn of the situation from her therapist.	PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE	
Coordinator revealed: -She worked 1st shift from 7:00 a.m 3 p.mShe admitted to taking client #1 and client #2 to her home on different occasionsShe reported she wanted to give clients the ability to earn moneyClient #1 cleaned her home 1 time and client #2 about 3 timesClient's would sprinkle carpet fresh on the carpet and vacuum, swept the kitchen floor, dust and took out recycle garbage "It was nothing more that client #1 and client #2 didShe provided opportunity to let clients earn cashThe clients were at her home about 1 ½ or 2 hours when they were thereShe paid client #1 and client #2 \$15.00 and provided lunchShe reported client #1 and client #2 agreedConfirmed she did not get approval from the guardiansClient #1's guardian learn of the situation from her therapist.	V 112	Continued From page 5	V 112			
-The allowance the facility gave clients was from \$5 and up to \$15.00 but based on behaviorsClients had to "level up" to get more moneyThe facility allowance was based on completion of chores, schoolwork, positive interaction and no lying and stealingThis was during Covid and clients wanted to get out the houseShe stopped months ago and when client #1 guardian thought it was a problem.  Interview on 5/26/21 with the Director/Qualified Professional #3 revealed: -They tried to get a little creative for clients to earn extra money.	V 112	Interview on 5/25/21 with the Program Coordinator revealed: -She worked 1st shift from 7:00 a.m 3 p.mShe admitted to taking client #1 and client #2 to her home on different occasionsShe reported she wanted to give clients the ability to earn moneyClient #1 cleaned her home 1 time and client #2 about 3 timesClient's would sprinkle carpet fresh on the carpet and vacuum, swept the kitchen floor, dust and took out recycle garbage "It was nothing more that client #1 and client #2 didShe provided opportunity to let clients earn cashThe clients were at her home about 1 ½ or 2 hours when they were thereShe paid client #1 and client #2 \$15.00 and provided lunchShe reported client #1 and client #2 agreedConfirmed she did not get approval from the guardiansClient #1's guardian learn of the situation from her therapistClients wanted some way to make moneyThe allowance the facility gave clients was from \$5 and up to \$15.00 but based on behaviorsClients had to "level up" to get more moneyThe facility allowance was based on completion of chores, schoolwork, positive interaction and no lying and stealingThis was during Covid and clients wanted to get out the houseShe stopped months ago and when client #1 guardian thought it was a problem.  Interview on 5/26/21 with the Director/Qualified Professional #3 revealed: -They tried to get a little creative for clients to	V 112			

Division of Health Service Regulation

STATE FORM 6899 If continuation sheet 6 of 19 AEDC11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:	(X3) DATE SURVEY COMPLETED			
	MHL001-259	B. WING	R <b>05/27/2021</b>			

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

### A MOTHER'S I OVE

### 1227 WESTMORLAND DRIVE BURLINGTON, NC 27215

AMOTHE	R'S LOVE BURLING	BURLINGTON, NC 27215			
(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			
V 112	Continued From page 6  -During Covid they couldn't get jobsIt was one or two weekends the program coordinator took client #1 and client #2 to the homeClient #1's guardian learned about the situation through her therapistClient #1 was excited to get out the house and earn and few dollarsClient #2 was given permission to go outside the home a lot moreShe did not think the guardians were aware beforehandShe explained the situation to client #1's guardianClient #1 went one timeThey just decided it was not a good ideaThey discussed it during the staff meetingsThey brought it up at the next staff meeting once they received the call from client #1s guardianShe met with the program coordinator individually afterwardsThey also had a staff meeting that following ThursdayShe confirmed she knew the program coordinator took client #1 and client #2 to her homeShe thought it would not be okay if client #1 and client #2 was not paidThe facility facilitated other activities for clients to earn money and now did not know what was acceptable.  Interview on 5/26/21 with the Director/QP #4 revealed: -Clients wanted to do things during CovidThey tried to get creative with the clientsThey took clients on trips before CovidShe learned about client#1 going to the program coordinator's home when she received an email from the guardian.	V 112			

STATE FORM AEDC11 If continuation sheet 7 of 19

Division of	of Health Service Regu	lation			FURIVI	APPROVED
AND DIAN OF CORRECTION INTERPRETATION NUMBERS		` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
MHL001-259			B. WING		05/2	7/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STA	TE, ZIP CODE		
A MOTHER'S LOVE			STMORLAND DE			
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
V 112	-Client #1 told her the program coordinator's an eventThe program coordin-She did not think it we have client #1's guardianClient #1 went to the home one timeShe was not aware of program coordinator's -She knew client #2 voordinator during outshe tried to give clie one-on-one basisClient #2 was approved. The moment she four with client #1 she stoleshe met with the profindividuallyShe addressed the interest of the stoleshe was addressed the interest and the stoleshe with the profindividually.	erapist she went to the shome to help prepare for nator paid client #1.  vas a big deal. she communicated with the program coordinator's of that client #2 went to the shome.  vas with the program tings. Ints time with staff on a ved to go to day events.  Ind out about the incident pped it.	V 112			
V 132	G.S. 131E-256(G) HO Allegations, & Protect G.S. §131E-256 HEA		V 132			

## REGISTRY

- (g) Health care facilities shall ensure that the Department is notified of all allegations against health care personnel, including injuries of unknown source, which appear to be related to any act listed in subdivision (a)(1) of this section. (which includes:
- a. Neglect or abuse of a resident in a healthcare facility or a person to whom home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided.

Division of Health Service Regulation

STATE FORM AEDC11 If continuation sheet 8 of 19

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:				
		MHL001-259	B. WING		R <b>05/27/2021</b>		
	NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  1227 WESTMORLAND DRIVE  BURLINGTON, NC 27215						
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	D BE COMPLETE		
V 132	in a health care facility (b) of this section inclicare services as define hospice services as dare being provided. c. Misappropriation of healthcare facility. d. Diversion of drugs facility or to a patient e. Fraud against a heap a patient or client for providing services). Facilities must have a acts are investigated to protect residents from the providing in procinvestigations must be investigations must be	of the property of a resident by, as defined in subsection ading places where home and by G.S. 131E-136 or refined by G.S. 131E-201 of the property of a subsection about the property of a subsection by G.S. 131E-201 of the property of a subsection and the property	V 132				
	failed to assure an all	ew and interview, the facility egation of exploitation was Care Personal Registry					

Division of Health Service Regulation

STATE FORM 6899 AEDC11 If continuation sheet 9 of 19

Division of	of Health Service Regu	lation			
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		MHL001-259	B. WING		R <b>05/27/2021</b>
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	TE ZIP CODE	•
TWAME OF T	KOVIDER OR GOLT EIER		STMORLAND DE		
A MOTHE	R'S LOVE		GTON, NC 27215		
(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 APPROP DEFICIENCY)	BE COMPLETE
V 132	Continued From page	9	V 132		
	Review on 5/25/21 of -Age 13Admission date of 11 -Diagnoses of Unspectation Deficit Hypersection - Company - Comp	Client #1's record revealed: //20/20. cified Depressive Disorder,			
	-Age 16Admission date of 10 -Diagnoses of Oppos Major Depressive Dis	Client #2's record revealed: 0/24/18. itional Defiant Disorder, order, Attention Deficit r, Combined Presentation.			
	Review on 5/25/21 of the Complaint dated 4/3/21 revealed:  - "[Client #1] reported that the [Program Coordinator] took [Client #1] and another [Client #2] to their home and paid [Client #1] and [Client #2] \$15.00 to clean. [Client #1] and [Client #2] reported [Client #1] and [Client #2] volunteered to clean."  - "The [Director/Qualified Professional] was notified and reported that [Client #1] and [Client #2] could work and volunteer to earn money when supervised by the [Director/Qualified Professional] and [Program Coordinator]. The chores were minimal and not strenuous."  -The facility did not report the allegation to HCPR.				
	Professional #3 revea -She was responsible -She did not understa				

earning funds.

-She reported the goal was to improve clients independent living skills and self-esteem.

-The facility facilitated other activities for clients to earn money and now did not know what was

STATE FORM 6899 AEDC11 If continuation sheet 10 of 19

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:	(X3) DATE SURVEY COMPLETED
	MHL001-259	B. WING	R 05/27/2021
	11112001-200	<u> </u>	03/2//2021

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

### A MOTHER'S LOVE

### 1227 WESTMORLAND DRIVE BURLINGTON, NC 27215

AWOTHER	B	URLINGTON, NC 27215		
(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 132	Continued From page 10	V 132		
	acceptableShe confirmed the allegation was not reported HCPR.	to		
V 133	G.S. 122C-80 Criminal History Record Check	V 133		
	G.S. §122C-80 CRIMINAL HISTORY RECORD CHECK REQUIRED FOR CERTAIN APPLICANTS FOR EMPLOYMENT.  (a) Definition As used in this section, the term "provider" applies to an area authority/county program and any provider of mental health, developmental disability, and substance abuse services that is licensable under Article 2 of this Chapter.  (b) Requirement An offer of employment by a provider licensed under this Chapter to an applicant to fill a position that does not require to applicant to have an occupational license is conditioned on consent to a State and national criminal history record check of the applicant. If the applicant has been a resident of this State feless than five years, then the offer of employment is conditioned on consent to a State and national criminal history record check of the applicant. To national criminal history record check of the applicant. If the applicant has been a resident of this State for the applic	the for		
	Justice under G.S. 114-19.10 to conduct a criminal history record check required by this			

Division of Health Service Regulation

STATE FORM 6899 AEDC11 If continuation sheet 11 of 19

Division of Health Service Regulation

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:	(X3) DATE SURVEY COMPLETED		
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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE					

## A MOTHER'S LOVE

### 1227 WESTMORLAND DRIVE BURLINGTON, NC 27215

AWOTHE	BUR	LINGTON, NC 27215	5	
(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 133	Continued From page 11 section or shall submit a request to a private entity to conduct a State criminal history record check required by this section. Notwithstanding G.S. 114-19.10, the Department of Justice shall return the results of national criminal history record checks for employment positions not covered by Public Law 105-277 to the Department of Health and Human Services, Criminal Records Check Unit. Within five business days of receipt of the national criminal history of the person, the Department of Health and Human Services, Criminal Records Check Unit, shall notify the provider as to whether the information received may affect the employability of the applicant. In no case shall the results of the national criminal history record check be shared with the provider. Providers shall make available upon request verification that a criminal history check has been completed on any staff covered by this section. A county that has adopted an appropriate local ordinance and has access to the Division of Criminal Information data bank may conduct on behalf of a provider a State criminal history record check required by this section without the provider having to submit a request to the Department of Justice. In such a case, the county shall commence with the State criminal history record check required by this section within five business days of the conditional offer of employment by the provider. All criminal history information received by the provider is confidential and may not be disclosed, except to the applicant as provided in subsection (c) of this section. For purposes of this subsection, the term "private entity" means a business regularly engaged in conducting criminal history record checks utilizing public records obtained from a State agency. (c) Action If an applicant's criminal history	V 133	DEFICIENCY)	
	alth Service Regulation	ı		

Division of Health Service Regulation

STATE FORM 6899 AEDC11 If continuation sheet 12 of 19

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		A. BOILDING.		R		
		MHL001-259	B. WING		1	7/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE		
A MOTUE	R'S LOVE	1227 WE	STMORLAND DE	RIVE		
AWOTHE	K S LOVE	BURLING	TON, NC 27215	i		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
V 133	Continued From page	e 12	V 133			
	record check reveals a relevant offense, th of the following factor hire the applicant:  (1) The level and seri (2) The date of the cr (3) The age of the pe conviction.  (4) The circumstance commission of the cri (5) The nexus between the person and the jour filled.  (6) The prison, jail, properson since the date (7) The subsequent of a relevant offense. The fact of conviction shall not be a bar to elisted factors shall be lifthe provider disquate consideration of the reprovider may disclose the criminal history reto the disqualification of	one or more convictions of e provider shall consider all is in determining whether to ousness of the crime.  ime.  rson at the time of the surrounding the me, if known.  en the criminal conduct of b duties of the position to be robation, parole, aployment records of the ethe crime was committed.  commission by the person of a of a relevant offense alone employment; however, the considered by the provider. lifies an applicant after elevant factors, then the enformation contained in ecord check that is relevant, but may not provide a copy	V 133			

Division of Health Service Regulation

STATE FORM 6899 AEDC11 If continuation sheet 13 of 19

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:	(X3) DATE SURVEY COMPLETED
	MHL001-259	B. WING	R <b>05/27/2021</b>
	•	•	-

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

### A MOTHER'S I OVE

### 1227 WESTMORLAND DRIVE BURLINGTON, NC 27215

A MOTHER'S LOVE  BURLINGTON, NC 27215					
(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 133	Continued From page 13	V 133			
	(e) Relevant Offense As used in this section, "relevant offense" means a county, state, or federal criminal history of conviction or pending indictment of a crime, whether a misdemeanor or felony, that bears upon an individual's fitness to have responsibility for the safety and well-being of persons needing mental health, developmental disabilities, or substance abuse services. These crimes include the criminal offenses set forth in any of the following Articles of Chapter 14 of the General Statutes: Article 5, Counterfeiting and Issuing Monetary Substitutes; Article 5A, Endangering Executive and Legislative Officers; Article 6, Homicide; Article 7A, Rape and Other Sex Offenses; Article 8, Assaults; Article 10, Kidnapping and Abduction; Article 13, Malicious Injury or Damage by Use of Explosive or Incendiary Device or Material; Article 14, Burglary and Other Housebreakings; Article 15, Arson and Other Burnings; Article 16, Larceny; Article 17, Robbery; Article 18, Embezzlement; Article 19, False Pretenses and Cheats; Article 19A, Obtaining Property or Services by False or Fraudulent Use of Credit Device or Other Means; Article 19B, Financial Transaction Card Crime Act; Article 20, Frauds; Article 21, Forgery; Article 26, Offenses Against Public Morality and Decency; Article 26A, Adult Establishments; Article 27, Prostitution; Article 28, Perjury; Article 29, Bribery; Article 31, Misconduct in Public Office; Article 35, Offenses Against the Public Peace; Article 36A, Riots and Civil Disorders; Article 39, Protection of Minors; Article 40, Protection of the Family; Article 59, Public Intoxication; and Article 60, Computer-Related Crime. These crimes also include possession or sale of drugs in violation of the North Carolina Controlled Substances Act, Article 5 of Chapter 90 of the General Statutes, and alcohol-related				

Division of Health Service Regulation

STATE FORM 6899 AEDC11 If continuation sheet 14 of 19

Division of Health Service Regulation

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVE COMPLETED	
		B. WING		R		
		MHL001-259	b. WING		05/27/20	021
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
A MOTHE	R'S LOVE	1227 WES	TMORLAND DI	RIVE		
AMOTHE		BURLING	TON, NC 2721	5		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE CO	(X5) OMPLETE DATE
V 133	Continued From page	: 14	V 133			
	violation of G.S. 18B-impaired in violation of G.S. 20-138.5.  (f) Penalty for Furnish applicant for employment applicant for employment application of an employment application of a Clark (g) Conditional Employment application obtaining the results of check regarding the afollowing requirement (1) The provider shall prior to obtaining the acriminal history record subsection (b) of this fingerprint cards as refully the provider shall criminal history record subsection (b) of this fingerprint cards as refully the provider shall criminal history record business days after the conditional employme 2001-155, s. 1; 2004-2005-4, ss. 1, 2, 3, 4, and the provider is not met a Based on record reviet failed to ensure the strength of the provider and the provider shall criminal history record business days after the conditional employme 2001-155, s. 1; 2004-2005-4, ss. 1, 2, 3, 4, and the provider shall criminal history record business days after the conditional employme 2001-155, s. 1; 2004-2005-4, ss. 1, 2, 3, 4, and the provider shall criminal history record business days after the conditional employment and the provider shall criminal history record business days after the conditional employment and the provider shall criminal history record business days after the conditional employment and the provider shall criminal history record subsection (b) of this fingerprint cards as refused as the provider shall criminal history record subsection (b) of this fingerprint cards as refused as the provider shall criminal history record subsection (c) of this fingerprint cards as refused as the provider shall prior to obtaining the acriminal history record subsection (b) of this fingerprint cards as refused as the provider shall prior to obtaining the acriminal history record subsection (c) of the provider shall prior to obtaining the acriminal history record subsection (d) of this fingerprint cards as refused as the provider shall prior to obtain the provider shall prior to obtain the provider shall prior to obtain the prior to	ing False Information Any ment who willfully furnishes, a gives false information on cation that is the basis for a dicheck under this section ass A1 misdemeanor.  Tyment A provider may conditionally prior to of a criminal history record pplicant if both of the sare met:  Tho the employ an applicant applicant's consent for dicheck as required in section or the completed equired in G.S. 114-19.10. Submit the request for a dicheck not later than five the individual begins ent. (2000-154, s. 4; 124, ss. 10.19D(c), (h); 5(a); 2007-444, s. 3.)				
	was ordered within five the conditional offer on Program Coordinator.					

Division of Health Service Regulation

Review on 5/27/21 of Program Coordinator's

STATE FORM 6899 AEDC11 If continuation sheet 15 of 19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:	INSTRUCTION	(X3) DATE SURVEY COMPLETED
		MHL001-259	B. WING		R <b>05/27/2021</b>
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE,	ZIP CODE	
A MOTHE	R'S I OVE	1227 WE	STMORLAND DRIV	E	
AMOTTIE	K O LOVE	BURLIN	GTON, NC 27215		
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE COMPL
V 133	Continued From page	e 15	V 133		
	Interview on 5/27/21 Professional #3 revershe completed backemployeesShe confirmed the P	rd check was order 8/20/20. with the Director/Qualified			
	date.	itutes a re-cited deficiency			
V 367	10A NCAC 27G .060 REPORTING REQUI CATEGORY A AND E	IREMENTS FOR	V 367		

level II incidents, except deaths, that occur during the provision of billable services or while the consumer is on the providers premises or level III incidents and level II deaths involving the clients to whom the provider rendered any service within 90 days prior to the incident to the LME responsible for the catchment area where services are provided within 72 hours of becoming aware of the incident. The report shall be submitted on a form provided by the Secretary. The report may be submitted via mail, in person, facsimile or encrypted electronic means. The report shall include the following information:

- reporting provider contact and (1) identification information:
- client identification information; (2)
- (3) type of incident;

Division of Health Service Regulation

STATE FORM 6899 AEDC11 If continuation sheet 16 of 19

Division of Health Service Regulation

Division	of Health Service Regu	lation			
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	TION NUMBER: A. BUILDING:		COMPLETED
			_		
			D WING		R
		MHL001-259	B. WING		05/27/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE ZIP CODE	
A MOTHE	R'S LOVE		TMORLAND DI		
		BURLING	TON, NC 2721	5	
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	( - /
PREFIX	,	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE	
TAG	REGULATORT OR L	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	MATE DATE
				,	
V 367	Continued From page	e 16	V 367		
	(4) description				
	` '	e effort to determine the			
	cause of the incident;				
	(6) other individ	duals or authorities notified			
	or responding.				
	(b) Category A and B	B providers shall explain any			
	missing or incomplete	e information. The provider			
	shall submit an updat	ed report to all required			
	report recipients by th	ne end of the next business			
	day whenever:				
	-	r has reason to believe that			
	information provided i				
	•	g or otherwise unreliable; or			
		obtains information			
		ent form that was previously			
	unavailable.	one form that was providuoly			
		providers shall submit,			
		ME, other information			
	obtained regarding th				
	•	ords including confidential			
	<ul><li>(1) hospital recinformation;</li></ul>	ords including confidential			
	·	than authoritian, and			
		other authorities; and			
		r's response to the incident.			
	` '	3 providers shall send a copy			
		reports to the Division of			
		opmental Disabilities and			
		rvices within 72 hours of			
	<u> </u>	ne incident. Category A			
	providers shall send a				
		client death to the Division of			
		ation within 72 hours of			
	_	ne incident. In cases of			
		ven days of use of seclusion			
		der shall report the death			
	immediately, as requi	red by 10A NCAC 26C			
	.0300 and 10A NCAC	27E .0104(e)(18).			
		providers shall send a			
		LME responsible for the			

Division of Health Service Regulation

catchment area where services are provided.

STATE FORM 6899 AEDC11 If continuation sheet 17 of 19

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED						
ANDILAN	or connection	IDENTIFICATION NOMBER.	A. BUILDING: _								
		MHL001-259	B. WING		R <b>05/27/2021</b>						
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE											
A MOTHER'S LOVE 1227 WESTMORLAND DRIVE BURLINGTON, NC 27215											
0.0.15	CLIMMADY CT				d 0.50	$\dashv$					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD	PROVIDER'S PLAN OF CORRECTION (X5) (EACH CORRECTIVE ACTION SHOULD BE ROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (X5) COMPLETE DATE						
V 367	Continued From page 17		V 367								
	The report shall be suby the Secretary via exinclude summary info (1) medication definition of a level II (2) restrictive in the definition of a level (3) searches of (4) seizures of the possession of a compact (5) the total numerical incidents that occurre (6) a statement been no reportable in incidents have occurrence tany of the criteria.	ubmitted on a form provided electronic means and shall rmation as follows: errors that do not meet the or level III incident; atterventions that do not meet el II or level III incident; a client or his living area; client property or property in lient; mber of level II and level III ed; and a indicating that there have cidents whenever no ed during the quarter that ia as set forth in Paragraphs e and Subparagraphs (1)									
	failed to ensure a Lev completed and submi	ew and interview the facility rel II incident report was itted to the Local Managed Organization (LME/MCO)									
	-Age 13Admission date of 11 -Diagnoses of Unspe Attention Deficit Hype	cified Depressive Disorder,									

Division of Health Service Regulation

STATE FORM 6899 AEDC11 If continuation sheet 18 of 19

	i riealtii Service Regu									
STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION DENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED					
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	DENTIFICATION NUMBER:  A. BUILDING:		COMPLETED					
MHL001-259		B. WING		R <b>05/27/2021</b>						
		1 1111111111111111111111111111111111111			1 03/21/2	-041				
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE						
A MOTUERIO LOVE 1227 WESTMORLAND DRIVE										
A MOTHER'S LOVE  BURLINGTON, NC 27215										
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)				
PREFIX	(EACH DEFICIENCY 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 367	Continued From page 18		V 367							
	Continuou i rom page									
		Client #2's record revealed:								
	-Age 16.									
	-Admission date of 10/24/18.									
		itional Defiant Disorder,								
	Major Depressive Disorder, Attention Deficit									
	Hyperactivity Disorde	r, Combined Presentation.								
	D : 5/05/04 6									
	Review on 5/25/21 of the Complaint dated									
	4/13/21 revealed:									
	- "[Client #1] reported that the [Program									
	Coordinator] took [Client #1] and another [Client									
	#2] to their home and paid [Client #1] and [Client									
	#2] \$15.00 to clean. [Client #1] and [Client #2]									
	reported [Client #1] and [Client #2] volunteered to									
	clean."									
	- "The [Director/Qualified Professional] was									
	notified and reported that [Client #1] and [Client									
	#2] could work and volunteer to earn money when									
	supervised by the [Director/Qualified									
	Professional] and [Program Coordinator]. The									
	chores were minimal and not strenuous."									
	-The facility did not complete an incident report.									
	Interview on 5/27/21 with the Director/Qualified									
	Professional #3 revealed:									
	-She was responsible for completing incident									
	reports.									
	-She did not understand the problem with client's									
	earning funds.	ind the problem with dients								
	_	al was to improve clients								
	-She reported the goal was to improve clients independent living skills and self-esteem.									
	-The facility facilitated other activities for clients to									
	earn money and now did not know what was									
acceptable.										
-She confirmed an incident report was not										
	completed.									
			1	1						

Division of Health Service Regulation

STATE FORM 6899 AEDC11 If continuation sheet 19 of 19