STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED			
7.1.12 . 2.1.1		1521111110711101111011152111	A. BUILDING: _		_	
		MHL074-255	B. WING		R 08/04/2021	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
PARADIG	M 4 KIDS	4075 PITT				
	CLIMMA DV CT	AYDEN, NO		DROVIDEDIC DI ANI OF CORRECTION	1	
(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 COMPLETE	
V 000	INITIAL COMMENTS		V 000			
	completed on August was unsubstantiated Deficiencies were cite.  This facility is licensee	and follow up survey was 4, 2021. The complaint (Intake #NC00179628). ed. d for the following service 27G .5600B Supervised				
		Developmental Disabilities.				
V 118	27G .0209 (C) Medica	ation Requirements	V 118			
	only be administered order of a person autidrugs.  (2) Medications shall clients only when auticlient's physician.  (3) Medications, incluadministered only by unlicensed persons trepharmacist or other leprivileged to prepare (4) A Medication Admall drugs administered current. Medications a recorded immediately MAR is to include the (A) client's name;  (B) name, strength, a (C) instructions for addictions of the control of	istration: n-prescription drugs shall to a client on the written chorized by law to prescribe be self-administered by chorized in writing by the ding injections, shall be licensed persons, or by rained by a registered nurse, regally qualified person and and administer medications. clinistration Record (MAR) of d to each client must be kept administered shall be or after administration. The following:				

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

TITLE (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			B. WINC		R
		MHL074-255	B. WING		08/04/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE	
PARADIG	M 4 KIDS	4075 PI	TT STREET		
		AYDEN,	NC 28513		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES  YMUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCED TO TOTAL DEFICIENCED TOTAL DEFICIENCED TO TOTAL DEFICIENCED TOTAL	TION SHOULD BE COMPLET THE APPROPRIATE DATE
V 118	Continued From page	e 1	V 118		
	file followed up by ap with a physician.	pointment or consultation			
	facility failed to keep	as evidenced by: ews and interviews the the MARs current affecting (#1, #2 and #3). The			
	-12 year old maleAdmission date of 0Diagnoses of Autism	n Spectrum Disorder, e Disorder and Severe			
	orders dated 06/16/2 -Clonidine HCL 0.1 n Attention Deficit Hypotablet by mouth every -Divalproex DR 125n bi-polar disorders) Ta every morningTrazodone 50mg (attablets by mouth every -Mirtazapine 15mg (aby mouth every even -Clonidine HCL 0.2m every morning and atalian -Risperidone 2mg (attablets) mouth every morning	ng (milligram) (treats eractivity Disorder) Take 1 y evening at 5pm. ng (treats seizures and ake 2 capsules by mouth ntidepressant) Take 1 1/2 ry evening. antidepressant) Take 1 tablet ing at 6pm. g Take 1 tablet by mouth t noon. ntipsychotic) Take 1 tablet by			

Division of Health Service Regulation

STATE FORM BL0Q11 If continuation sheet 2 of 12

Division of	<u>of Health Service Regu</u>	lation				
	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION		CONSTRUCTION	(X3) DATE S		
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLI	ETED
					-	,
		MUI 074 255	B. WING		F	
		MHL074-255			1 08/0	4/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE		
		4075 PIT	T STREET			
PARADIG	M 4 KIDS	AYDEN, I	NC 28513			
(V4) ID	SLIMMARY ST	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTION	<u> </u>	(VE)
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE	RIATE	DATE
				DEFICIENCY)		
V 118	Continued From page	2	V 118			
	-Melatonin 5mg (slee	p aid) Dissolve 1 tablet by				
	mouth every night at					
		tool softner) Take 1 tablet by				
	mouth every night at					
		constipation) Mix 1 & 1/2				
	,	d by mouth every night at				
	bedtime.	a a,a a a a ,g a				
	Review on 08/04/21 of	of client #1's August 2021				
	MAR revealed the fol	lowing blanks:				
	-Clonidine HCL 0.1mg	g- 08/01/21, 08/02/21,				
	08/03/21.					
	-Divalproex DR 125m	ig-08/01/21, 08/04/21 at				
	8am.					
	-Trazodone 50mg-08	/01/21, 08/02/21, 08/03/21 at				
	6pm.					
	-Mirtazapine 15mg-08	3/01/21, 08/02/21, 08/03/21				
	at 6pm.					
		g-08/01/21 at 8am and				
	12pm, 08/04/21 at 8a					
		/01/21 at 8am and 5pm,				
	08/02/21 at 5pm, 08/0	03/21 at 5pm, 08/04/21 at				
	8am.					
		ıg-08/01/21, 08/02/21,				
	08/03/21 at 8pm.					
	=	1/21, 08/02/21, 08/03/21 at				
	8pm.	4 00/00/04 00/00/04				
		1, 08/02/21, 08/03/21 at				
	8pm.	01 09/02/21 09/02/21 at				
		21, 08/02/21, 08/03/21 at				
	8pm.					
	Client #1 was unable	to be interviewed due to				
	being non-verbal.	to be interviewed add to				
	boiling Holl-Volbal.					
	Review on 08/04/21 of	of client #2's record				
	revealed:					
	-16 year old male.					
	-Admission date of 03	3/07/19.				
		Spectrum Disorder and				
	J		1			ı

STATE FORM 6899 BL0Q11 If continuation sheet 3 of 12

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(V2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	' '		COMPLETED
			A. BUILDING: _		
					R
		MHL074-255	B. WING		08/04/2021
NAME OF D	ROVIDER OR SUPPLIER	STREET VI	DDRESS, CITY, STA	TE ZIR CODE	
NAME OF T	NOVIDER OR GOLT EIER		, ,	11 L, 211 OOBL	
PARADIG	M 4 KIDS		T STREET		
		At DEN, I	NC 28513		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD	
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPI	
				DEFICIENCY)	
\/ 110	0 " 15	0	V 440		
V 118	Continued From page	e 3	V 118		
	Seizure Disorder.				
	Review on 08/04/21 of	of client #2's Physician			
	orders dated 02/10/2	1 revealed:			
	-Guanfacine HCL ER	3mg (treats ADHD) Take 1			
	tablet by mouth every				
		it (supplement) Take 1 tablet			
	by mouth every morn				
		3350 (treats constipation)			
	· ·	8 ounces of liquid by mouth			
	every day.				
		s (Supplement) Chew and			
	_	y mouth every morning.			
		ng (treats seizures) Take 1			
	tablet by mouth 2 time				
		ep aid) Take 1 capsule by			
	mouth every night at	beatime.			
	Davious on 09/04/21 a	of client #2!a August 2021			
	MAR revealed the following	of client #2's August 2021			
		3mg-08/01/21 at 8am.			
	-Vitamin D3 2,000 un	•			
	-	3350-08/01/21 at 8am.			
	-Flintstone's Gummie				
	-Oxcarbazepine 600n				
	-Melatonin 10mg-08/0	•			
		,			
	Attempted interview v	vith client #2 was			
		client #2 not answering any			
	questions.				
	Review on 08/04/21 of	of client #3's record			
	revealed:				
	-15 year old male.				
	-Admission date of 01				
		Disorder, Mild Intellectual			
	Disability and Disrupt	ive Mood Disorder.			
		of client #3's Physician			
	orders dated 06/16/2	1 revealed:			

Division of Health Service Regulation

STATE FORM BL0Q11 If continuation sheet 4 of 12

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C			SURVEY PLETED	
			A. BOILDING.	A. BUILDING:		Б
		MHL074-255	B. WING		08	R 8 <b>/04/2021</b>
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
DADADIC	M 4 KIDO	4075 PIT	T STREET			
PARADIG	WI 4 KIDS	AYDEN, I	NC 28513			
(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 AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
V 118	Continued From page	e 4	V 118			
	symptoms)- Take 1 ta -Trazodone 100mg (a by mouth every even -Haloperidol 5mg (an mouth every morning -Divalproex SOD DR bipolar disorder)-Take night at bedtime for n -Chlorpromazine 100 disorders)-Take 3 tab bedtime.  Review on 08/04/21 (a August 2021 MAR re -Benztropine MES 1n -Trazodone 100mg-0 -Haloperidol 5mg-08/ -Divalproex SOD DR -Chlorpromazine 100	tipsychotic)-Take 1 tablet by				
	-He did not normally	8/04/21 staff #1 revealed: work at that facility. n for another staff that was				
	-He administered me -The clients always re	dication to the clients. eceived their medication. to sign off on the MAR's edications.				
	MAR's when the med	d: le staff signed off on the lication was administered.				
	and must be correcte	itutes a re-cited deficiency d within 30 days.				

Division of Health Service Regulation

STATE FORM BL0Q11 If continuation sheet 5 of 12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION  A. BUILDING:  A. BUILDING:  R  (X3) DATE SURVEY COMPLETED  R  (X4) ID  PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  4075 PITT STREET  AYDEN, NC 28513  (X4) ID  PREFIX  (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX  REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG  CROSS-REFERENCED TO THE APPROPRIATE  PATE
MHL074-255  MHL074-255  MHL074-255  B. WING  B. WING  D8/04/2021  NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  4075 PITT STREET  AYDEN, NC 28513  (X4) ID PREFIX  CEACH DEFICIENCY MUST BE PRECEDED BY FULL  PREFIX  AYDEN, DEFICE OF CORRECTION PREFIX  (EACH CORRECTIVE ACTION SHOULD BE  COMPLETE
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  4075 PITT STREET  AYDEN, NC 28513  (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE  B. WING
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  4075 PITT STREET  AYDEN, NC 28513  (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE  B. WING
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  4075 PITT STREET  AYDEN, NC 28513  (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE  STREET ADDRESS, CITY, STATE, ZIP CODE  107 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE
PARADIGM 4 KIDS  4075 PITT STREET AYDEN, NC 28513  (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE
PARADIGM 4 KIDS  AYDEN, NC 28513  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE (COMPLETE COMPLETE COM
AYDEN, NC 28513  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE
THE IX
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE  DEFICIENCY)  DATE
V 367 27G .0604 Incident Reporting Requirements V 367
404 NOA 0 070 0004 INCIDENT
10A NCAC 27G .0604 INCIDENT
REPORTING REQUIREMENTS FOR
CATEGORY A AND B PROVIDERS
(a) Category A and B providers shall report all 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:
(1) reporting provider contact and
identification information;
(2) client identification information;
(3) type of incident;
(4) description of incident;
(5) status of the effort to determine the
cause of the incident; and
(6) other individuals or authorities notified
or responding.
(b) Category A and B providers shall explain any
missing or incomplete information. The provider
shall submit an updated report to all required
report recipients by the end of the next business
day whenever:
(1) the provider has reason to believe that information provided in the report may be
erroneous, misleading or otherwise unreliable; or
(2) the provider obtains information
required on the incident form that was previously
unavailable.

Division of Health Service Regulation

STATE FORM BL0Q11 If continuation sheet 6 of 12

Division of Health Service Regulation

	or riealth Service Regu				I	·
	OF DEFICIENCIES	CORRECTION INDENTIFICATION NUMBER		(X3) DATE S		
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLI	בובט
					F	,
		MHL074-255	B. WING		1	4/2021
		WII 1207 4-200			1 00/0	14/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
DADADIO	M 4 KIDO	4075 PITT	STREET			
PARADIGI	WI 4 KID3	AYDEN, N	C 28513			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	J	(X5)
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 367	Continued From page	e 6	V 367			
	(a) Catagory A and B	providers shall submit,				
		ME, other information				
	obtained regarding th					
		ords including confidential				
	information;	41				
		ther authorities; and				
		's response to the incident.				
	. ,	providers shall send a copy				
		reports to the Division of				
		opmental Disabilities and				
		rvices within 72 hours of				
	_	ne incident. Category A				
	providers shall send a	• •				
		client death to the Division of				
	~	ation within 72 hours of				
		e incident. In cases of				
		ven days of use of seclusion				
		der shall report the death				
		red by 10A NCAC 26C				
	.0300 and 10A NCAC	` ,` ,				
	. ,	providers shall send a				
		LME responsible for the				
		e services are provided.				
	•	ubmitted on a form provided				
	,	electronic means and shall				
	include summary info					
	( )	errors that do not meet the				
	definition of a level II	,				
	( )	nterventions that do not meet				
		el II or level III incident;				
		a client or his living area;				
	• •	client property or property in				
	the possession of a c	•				
	( - /	mber of level II and level III				
	incidents that occurre					
		indicating that there have				
	been no reportable in					
		ed during the quarter that				
	meet any of the criter	ia as set forth in Paragraphs	1			

Division of Health Service Regulation

STATE FORM BL0Q11 If continuation sheet 7 of 12

Division of Health Service Regulation

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X3) DATE A. BUILDING: COMP		E SURVEY PLETED	
			A. BOILDING	<del></del>		_
		MHL074-255	B. WING		08	R 3/ <b>04/2021</b>
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	E, ZIP CODE		
		4075 PIT	T STREET			
PARADIG	M 4 KIDS	AYDEN,	NC 28513			
(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 CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
			1	DEFICIENCY)	)	
V 367	Continued From page	e 7	V 367			
	(a) and (d) of this Rul through (4) of this Pa	e and Subparagraphs (1) ragraph.				
	facility failed to report home and host Local as required. The findi Review on 08/04/21 o	ews and interview, the a critical incident to the Management Entity (LME)				
	revealed no level II in allegation of abuse fo	cident report for the				
	investigation dated 0: "-On 7/23/21, house it was contacted by an Department stating the regarding a complain that time, they neede representative from F questioning. [House that [County] CPS (Contacted them to pe because they were unresponse since they lout at that time. [Hou QP (Qualified Profess contacted the officer in the contacted the contacted the officer in the contacted the contact	manager [House Manager] officer with [Town] Police nat they had been contacted t of bruises on [Client #1] At d to speak with a Paradigm, Inc. for Manager] was also informed hild Protective Services) had rform the welfare check nable to complete their initial had no one available to go use Manager] contacted the				
		by the officer asking if I was				

Division of Health Service Regulation

STATE FORM BL0Q11 If continuation sheet 8 of 12

Division of	of Health Service Regu	lation				
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S COMPLI	
			_		_	
		MHL074-255	B. WING		08/0	4/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STA	TE, ZIP CODE		
			T STREET	•		
PARADIG	M 4 KIDS		NC 28513			
(V4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTIO	N	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	COMPLETE DATE
V 367	Continued From page	e 8	V 367			
	aware of any injuries	or bruising that could have				
		Client #1]. [QP] responded				
		of any injuries or bruising that				
		recently.' He also asked				
		istreatment or anyone doing				
	, , ,	] that could cause him				
		responded by stating 'No, I				
	am not aware and no	s.' The officer also asked if				
		could explain why [Client #1]				
	_	on him, [QP] responded by				
		times in the past when he				
	_	placed in therapeutic holds or				
		had to physically keep him				
		nds because [Client #1] will				
		, and so forth or when he is				
	_	self-injurious behaviors and				
	staff are trying to kee	p him from hitting himself.				
	He also asked if there	e is any knowledge on how				
	[Client #1] could have	bruises that we don't know				
	about, [QP] responde	d by stating that he could				
	have hurt himself sind	ce he hits himself falls out on				
	the ground, jumps up	and down on the floor when				
	he is mad, etc. At the					
		e cell phone. [QP] explained				
		hat was going on. The				
	officer then asked the					
		ne responded by saying that				
		e physically assisted back in				
		hicle if he tries to run away				
		me, staff have to step in and				
		om punching himself and				
		ous behaviors. She also				
	•	he is a young boy who				
		ys on the trampoline, he				
	runs and falls so he c	ould have bruising from				

Division of Health Service Regulation

that, but I can assure you that none of my staff have hurt [Client #1]. She also explained that we have cameras within the home for that very purpose to protect our individuals as well as

STATE FORM BL0Q11 If continuation sheet 9 of 12

Division of Health Service Regulation

	or realth Service Negu		()(0) MILITED E	CONOTRILOTION	TOWN DATE OURWEY
	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
,	5. 55. u. 25. u. 3. u	1.52.11.11.10	A. BUILDING: _		00 22.125
					R
		MHL074-255	B. WING		08/04/2021
NAME OF D	ROVIDER OR SUPPLIER	STDEET AI	DDRESS, CITY, STA	TE ZID CODE	
NAME OF T	NOVIDEN ON SOLT LIEN			TL, ZII GODE	
PARADIG	M 4 KIDS		T STREET		
	T	AYDEN, I	NC 28513		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	( - /
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	
IAG		,	170	DEFICIENCY)	
V 207	0 " 15	0	1/ 207		
V 367	Continued From page	9	V 367		
	ensure that staff are p	performing their job duties			
	appropriately. [Licens	see] went on to explain that			
	[Client #1] has a guar	= -			
		Services who sees [Client			
	•	onth and can attest to how			
	he is cared for with ou				
		d the phone call and asked			
		r to the home to interview			
		the officer arrived at the			
		s in the living room with			
		rrival. He came up to [QP]			
		d and guided her towards			
	_	plained to [Client #1] that the			
		e him. The officer asked if			
		v him his room. [Client #1]			
	-	P] hand and walked back to			
		cer following. The officer			
		a series of question in			
		nswer (due to [Client #1]			
		e officer asked [Client #1] if			
		ody parts to see if there was			
		did not respond but stood			
		looked over [Client #1's]			
		n showed [QP] a small			
		[Client #1's] left leg about			
		nd small bruise on the back			
		he size of a nickel. The			
	bruises appeared to b				
		d to leave the home and			
	-	s aware how the old bruises			
		reas. [QP] responded 'No, I			
	_	ot notified of any injuries.'			
		locument injuries when they			
		onded by saying 'yes, staff			
		orts.' He then asked if we			
		I see at the moment, [QP]			
	_	cident reports would be in			
		per said, 'Ok, I will let DSS			
		I Services) know and they			
		v up because I didn't see			

Division of Health Service Regulation

STATE FORM BL0Q11 If continuation sheet 10 of 12

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C			E SURVEY IPLETED	
		MHL074-255	B. WING		0:	R 8/ <b>04/2021</b>
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	, ZIP CODE		
PARADIG	M 4 KIDS		TT STREET			
	T	·	NC 28513			
(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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
V 367	were described to hin see a black eye. That At that point the office information received behavioral history of concluded that there that there was any abmistreatment of [Client Level 1 and Level II in requested on two diffusurvey. Only Level I During interview on 0-The internal investigation.	ut, no major bruises as they n on the call and he did not ank you for your time, [QP].' er leftBased on the and gathered, and based on [Client #1], we have is no evidence to suggest ouse of [Client #1] or ant #1]."	V 367			
V 736	10A NCAC 27G .030: EXTERIOR REQUIR (c) Each facility and it maintained in a safe, manner and shall be odor.  This Rule is not met Based on observation	EMENTS ts grounds shall be clean, attractive and orderly kept free from offensive  as evidenced by: and interview, the facility a safe, clean, attractive	V 736			
	Observation on 08/04 am revealed:	1/21 at approximately 10:45				

Division of Health Service Regulation

STATE FORM BL0Q11 If continuation sheet 11 of 12

Division of Health Service Regulation

	OF DEFICIENCIES OF CORRECTION	DENTIES ATION NUMBER		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			7 50.25 to. <u>-</u>		R
		MHL074-255	B. WING		08/04/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
PARADIG	M 4 KIDS	4075 PITT AYDEN, N			
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI	()
PREFIX TAG		SC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROP	
V 736	Continued From page	<del>2</del> 11	V 736		
		exterior were dirty and			
	stained with grease a	nd debris. aying in the back yard.			
		had a hole in the bottom of			
	the entrance door.				
		door did not have a knob to			
	open and close the do -Client #1's bedroom	light fixture had two light			
		d a broken shade over the			
	light.				
	-The hall bathroom she exposed hole.	nower head area had			
	Interview on 08/04/21 revealed:	the Qualified Professional			
	-She was aware the hupdates.	nouse needed repairs and			
	This deficiency consti	itutes a re-cited deficiency d within 30 days.			

Division of Health Service Regulation

STATE FORM BL0Q11 If continuation sheet 12 of 12