` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				TE SURVEY MPLETED	
MHL011-247		B. WING		08/04/2021			
NAME OF I	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE			
LINCS			ANE/180 BU NOA, NC 28	CKEYE COVE ROAD 778			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE	
V 000	INITIAL COMMENT	S	V 000				
	on August 4, 2021. unsubstantiated (In Deficiencies were of This facility is licens category: 10A NCA Respite Services for	take #NC00178975). ited. sed for the following service C 27G. 5100 Community r Individuals of all Disability CAC 27G. 5400 Day Activity					
V 112	27G .0205 (C-D) Assessment/Treatn	nent/Habilitation Plan	V 112				
	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.						

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

(X6) DATE TITLE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		MHL011-247	B. WING		08/	04/2021
NAME OF	PROVIDER OR SUPPLIER	6 BYAS L	DDRESS, CITY, ST ANE/180 BUC ANOA, NC 287	KEYE COVE ROAD		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
V 112	Continued From pa	ge 1	V 112			
	facility failed to dev	views and interviews, the elop and implement strategies needs affecting 1 of 3 audited				
	-Date of Admission -Diagnoses: Severe Disability;, Angelma	e Intellectual Developmental an Syndrome; Epilepsy, Itermittent Explosive Disorder				
	from a local hospital -Client #1 was adm 6/28/21 through 7/8 obstruction related	f Client #1's medical records al revealed: itted to the hospital from 3/21 for a small bowel to foreign body ingestion of an f rubber gloves.				
	revealed: -Strengths and Preif he eats or drinks choked in the past food correctly and heat safely. He will a immediate aspiration quickly. Therefore, continually to ensur safely." -There were no idea	f Client #1's Treatment Plan ferences: "[Client #1]will choke anything too fast. He has because he does not chew his has a limited attention span to lso gulp liquids to the point of on if staff does not intervene he needs staff available he he is able to accept nutrition intified goals or strategies to issues with eating, or drinking				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
	MHL011-247		B. WING		08/04/2021	
NAME OF F	PROVIDER OR SUPPLIER	6 BYAS LA	, ,	STATE, ZIP CODE  CKEYE COVE ROAD  778		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU) CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
V 112	Client #1 from inges Interview on 8/2/21 -Client #1 was non- interview questions.  Interview on 8/2/21 -She was aware Cli -She did not know o stated, "I didn't ask, that's none of my bu Interview on 8/2/21 -She knew Client #* -She did not see Cli Program.  Interview on 8/2/21 Professional (QP) r -A Care Coordinato treatment plan for e -The QP used inform developed by the C client goals for the I -He stated, "I will loc clients) are doing for goals. I will ask staf see. I usually go fro -He was aware Clie for swallowing glove -Client #1's treatme	goals or strategies to prevent sting inedible items.  with Client #1 revealed: verbal and could not answer  with Staff #1 revealed: ent #1 had ingested gloves. details about the situation and I usually don't ask questions, usiness."  with Staff #2 revealed: 1 ate gloves. ient #1 with gloves at the Day with the Qualified evealed: r developed an annual each client. In a coordinator to create Day Program. ok back to see how they (the or the past year and make if and let them know what I me that to make the plan." ent #1 had been hospitalized	V 112			
V 736	, ,	ty and Grounds Maintenance	V 736			
	TOA NOAC 27 G .0303 LOCATION AND					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
MHL011-247		B. WING		08/04/2021		
NAME OF I	PROVIDER OR SUPPLIER		DDESS CITY S	STATE, ZIP CODE	1 00/0	7472021
NAIVIE OF I	-ROVIDER OR SUPPLIER			CKEYE COVE ROAD		
LINCS			NOA, NC 28			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
V 736	maintained in a safe		V 736			
	This Rule is not met as evidenced by: Based on observation and interviews, the facility was not maintained in a safe, clean and attractive manner. The findings are:					
	Observation of the facility and its grounds on 8/2/21 at approximately 9:55 am through 10:52 am revealed:  -There were pieces of old, splintered wood of various sizes; a broken wooden rocking chair; a broken wooden mop handle and metal door runners stored in a pile beside the sports equipment building which was in an outdoor area used by clients.  -An opened and unattended first aid kit which contained a pair of scissors and tweezers was laying on the counter and easily accessible to clients.  -A cylinder of oxygen was free standing on the floor of the classroom and was not stored in a secure manner to prevent tipping, or damage.  -There was an empty rack on the wall in the hallway with a sign that read "fire extinguisher" and the fire extinguisher was missingIn client bathroom #1 the toilet basin had brown					
	colored stains; an opened box of disposable gloves was stored inside the basin of a portable commode and a shelf which was accessible to clients contained a bottle of perineal cleanser and a bottle of disinfectant.					

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		MHL011-247	B. WING		08/	04/2021
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
LINCS			ANE/180 BUO NOA, NC 28	CKEYE COVE ROAD 778		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
V 736	PROVIDER OR SUPPLIER  6 BYAS LA  SWANNAN  SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)		V 736			

Division of Health Service Regulation

STATE FORM 5699 ZTDQ11 If continuation sheet 5 of 6

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
MHL011-247		B. WING		08/0	4/2021	
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE  CKEYE COVE ROAD		
LINCS		SWANNAI	NOA, NC 28	3778		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
V 736	-The fire extinguish in the hallway becare the wallCleaning supplies up in the medicationHe was surprised of found in the client beThe pile of wood a sports equipment beHe was not sure we sitting out in the claes.	er was missing from the rack use a client had pulled it off had always been kept locked in room. Cleaning supplies had been eathrooms. Indicate the had been beside the uilding for quite a while. The hy first aid kits had been left	V 736			