STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
	MHL042-076				00/4	2/2024
			l.		08/1	3/2021
NAME OF I	PROVIDER OR SUPPLIER		IGORY DRIV	STATE, ZIP CODE		
HOMECA	ARE MANAGEMENT	CORPORATION	E RAPIDS, N	•		
(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	(X5) COMPLETE DATE
V 000	INITIAL COMMEN	тѕ	V 000			
	on August 13, 2021 substantiated (intak unsubstantiated (in Deficiencies were of This facility is licens	sed for the following service C 27G .5400 Day Activity for				
V 367		Reporting Requirements	V 367			
	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.					

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 CONSTRUCTION (X3) A. BUILDING:			(X3) DATE SURVEY COMPLETED	
	MHL042-076		B. WING		08/1	3/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
HOMEC	HOMECARE MANAGEMENT CORPORATION 1165 GRE ROANOK			E, SUITE A C 27870		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
V 367	missing or incompleshall submit an upor report recipients by day whenever: (1) the provide erroneous, mislead (2) the provide erroneous, mislead (2) the provide required on the incidence unavailable. (c) Category A and upon request by the obtained regarding (1) hospital minformation; (2) reports by (3) the provided (4) Category A and of all level III incided Mental Health, Devento Substance Abuse Substance A	In B providers shall explain any sete information. The provider lated report to all required the end of the next business. The has reason to believe that ad in the report may be ling or otherwise unreliable; or der obtains information ident form that was previously. B providers shall submit, the LME, other information the incident, including: the ecords including confidential of other authorities; and der's response to the incident. B providers shall send a copy of the incident. Category A do a copy of all level III a client death to the Division of seven days of use of seclusion vider shall report the death quired by 10A NCAC 26C AC 27E .0104(e)(18). B providers shall send a he LME responsible for the ere services are provided. Submitted on a form provided a electronic means and shall aformation as follows: on errors that do not meet the III or level III incident;	V 367			

Division of Health Service Regulation

STATE FORM 6899 WYSV11 If continuation sheet 2 of 8

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION		E SURVEY PLETED	
		MHL042-076	B. WING		08/	13/2021
	PROVIDER OR SUPPLIER	CORPORATION 1165 GRE	DRESS, CITY, S GORY DRIV E RAPIDS, N			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
V 367	(2) restrictive the definition of a le (3) searches (4) seizures (5) the possession of a (5) the total nincidents that occur (6) a statement been no reportable incidents have occur meet any of the crit	interventions that do not meet evel II or level III incident; of a client or his living area; of client property or property in client; number of level II and level III and ent indicating that there have incidents whenever no arred during the quarter that eria as set forth in Paragraphs rule and Subparagraphs (1)	V 367			
	failed to ensure a L completed within 72 audited clients (#1) Record review on 8 revealed: - Admission - Diagnoses: Disorder, Moderate Seizure Disorder, L intractable without s (Systemic Lupus En Deficiency -No documenta	view and interview, the facility evel II incident report was 2 hours affecting one of three				

Division of Health Service Regulation STATE FORM

TE FORM 6899 WYSV11 If continuation sheet 3 of 8

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					X3) DATE SURVEY COMPLETED	
	MHL042-076	B. WING		08/1	3/2021	
NAME OF PROVIDER OR SUPPLIED HOMECARE MANAGEMENT	CORPORATION 1165 GRE	DRESS, CITY, S EGORY DRIV E RAPIDS, N				
PREFIX (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOUT CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE	
revealed: - No docum reporting to the In System (IRIS) Review on 8/13/2 by the Staff #1/Cli Professional (Stafent - The facility notes of documer #1 - "May 13, #1/CS/QP] into repurple bruise on colleg. Staff stated signification with toileting. [Stafent in the office. Client state in phrases to be a purple bruise on the client who resides (AFL) home." - Separate Support staff obsome arm (lower) that we bracelet. [Staff #1 private, but was not the bruise." - "6/22/21 prestroom due to Equipple bruise on compared was discovered a toileting at the day not able to determ bruises. Staff exp #1/CS/QP] inform documented and	age 3 8/3/21 of facility records mentation of bruises or incident cident Response Information 1 of handwritten notes provided ncal Supervisor/Qualified ff #1/CS/QP) revealed: y had two handwritten pages of ted bruises observed on Client 2021 Staff [#3] called [Staff stroom due to observing a slient's [initials of Client #1] right the noticed while assisting client ff #1/CS/QP] interviewed client is not completely verbal but that '[Person #1] hit her' and the bed'. [Person #1] is another in Alternatative Family Living entry with no date: "Day erved purple bruise on client left was covered by one gold /CS/QP] spoke with client of able to determine the cause Staff #1/CS/QP] was called into pay Support Staff noticing a slient's buttocks and leg. Bruise is staff was assisting client with we program. [Staff #1/CS/QP] was nine from client the cause of the ressed concern. [Staff ed staff that bruises are being [Staff #1/CS/QP] will continue to ment further bruises or					

Division of Health Service Regulation STATE FORM

WYSV11 If continuation sheet 4 of 8

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION (X3) DATE COMP		SURVEY LETED	
	MHL042-076		B. WING		08/1	3/2021
NAME OF I	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE		
HOMECARE MANAGEMENT CORPORATION			GORY DRIVI E RAPIDS, N			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT 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 APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
V 367	Continued From pa	ge 4	V 367			
V-500	- She did not for Client #1's susp - She was re IRIS report - She hesitat investigating the call Interview on 8/13/2 Services Social Worder - An Adult Privas conducted regall - "[Person #7 client" in the Alternation	sponsible for submitting the led to report without use of the bruises I the Department of Social rker reported: otective Services investigation arding bruises found on Client I] was not identified as a attive Family Living Home	W.500			
V 500	10A NCAC 27D .01 RESTRICTIONS AI (a) The governing assures the implem G.S. 122C-65, and (b) The governing implement policy to (1) all instance abuse, neglect or ereported to the Couservices as specific G.S. 7A, Article 44; (2) procedure instituted in accordance when a meropresent serious risk Particular attention neuroleptic medicar (c) In addition to the 10A NCAC 27E .01	body shall develop and assure that: ses of alleged or suspected exploitation of clients are nty Department of Social ed in G.S. 108A, Article 6 or and es and safeguards are ance with sound medical edication that is known to a to the client is prescribed. shall be given to the use of	V 500			

Division of Health Service Regulation STATE FORM

6899 WYSV11 If continuation sheet 5 of 8

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1185 GREGORY DRIVE, SUITE A ROANOKE RAPIDS, NC 27870 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST SEE PRECEDED BY FLUX) FREGULATORY OR IES DESTIFYING INFORMATION) V 500 Continued From page 5 that identifies: (1) any restrictive intervention that is prohibited from use within the facility, and (2) in a 24-hour facility, the circumstances under which staff are prohibited from restricting the rights of a client. (d) if the governing body allows the use of restrictive interventions or i, in a 24-hour facility, the restrictions of client rights specified in G. S. 122C-62(b) and (d) are allowed, the policy shall identify: (1) the permitted restrictive interventions or allowed restrictions, and involuntary client who refuses the use of restrictive interventions. (e) If restrictive interventions are allowed for use within the facility, the governing body shall develop and implement policy that assures compilance with Subchapter 27E, Section .0100, which includes: (1) the designation of an individual, who has been trained and who has demonstrated competence to use restrictive interventions, to provide written authorization for the use of restrictive interventions when the original order is renewed for up to a total of 24 hours in accordance with the time limits specified in 10A NCAC 27E. 0104(e)(10)(E); (2) the designation of an individual to be responsible for reviews of the use of restrictive interventions and involution to the use of restrictive interventions are individual to be responsible for reviews of the use of restrictive interventions are individual to be responsible for reviews of the use of restrictive interventions are limited and who has been trained for the use of restrictive interventions are limited and the limits specified in 10A NCAC 27E. 0104(e)(10)(E);	STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		
NOMECARE MANAGEMENT CORPORATION 1165 GREGORY DRIVE, SUITE A ROANOKE RAPIDS, NC 27870		MHL042-076		B. WING		08/1	3/2021
(24) D SUMMARY STATEMENT OF DEFICIENCIES D PROVIDERS PLAN OF CORRECTION (EACH CORNECTIVE ACTION SHOULD BE COME. TAG.) PREFIX TAG. PROPRIET PROPRIET	NAME OF F	NAME OF PROVIDER OR SUPPLIER STREET			STATE, ZIP CODE		
PRÉFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) V 500 Continued From page 5 that identifies: (1) any restrictive intervention that is prohibited from use within the facility; and (2) in a 24-hour facility, the circumstances under which staff are prohibited from use within the restrictive interventions or if, in a 24-hour facility, the restrictive interventions or if, in a 24-hour facility, the restrictive interventions or if, in a 24-hour facility, the restrictive interventions or if, in a 24-hour facility, the restrictions of client rights specified in G.S. 122C-62(b) and (d) are allowed, the policy shall identify: (1) the permitted restrictive interventions or allowed restrictions; (2) the individual responsible for informing the client; and (3) the due process procedures for an involuntary client who refuses the use of restrictive interventions. (e) If restrictive interventions are allowed for use within the facility, the governing body shall develop and implement policy that assures compliance with Subchapter 27E, Section .0100, which includes: (1) the designation of an individual, who has been trained and who has demonstrated competence to use restrictive interventions, to provide written authorization for the use of restrictive interventions when the original order is renewed for up to a total of 24 hours in accordance with the time limits specified in 10A NCAC 27E. 1014(e)(10(E); (2) the designation of an individual to be responsible for reviews of the use of restrictive interventions; and	HOMECA	ARE MANAGEMENT (CRPORATION				
that identifies: (1) any restrictive intervention that is prohibited from use within the facility; and (2) in a 24-hour facility, the circumstances under which staff are prohibited from restricting the rights of a client. (d) If the governing body allows the use of restrictive interventions or if, in a 24-hour facility, the restrictions of client rights specified in G.S. 122C-62(b) and (d) are allowed, the policy shall identify: (1) the permitted restrictive interventions or allowed restrictions; (2) the individual responsible for informing the client; and (3) the due process procedures for an involuntary client who refuses the use of restrictive interventions. (e) If restrictive interventions are allowed for use within the facility, the governing body shall develop and implement policy that assures compliance with Subchapter 27E, Section .0100, which includes: (1) the designation of an individual, who has been trained and who has demonstrated competence to use restrictive interventions, to provide written authorization for the use of restrictive intervention when the original order is renewed for up to a total of 24 hours in accordance with the time limits specified in 10A NCAC 27E_1014(e)[10](E); (2) the designation of an individual to be responsible for reviews of the use of restrictive interventions, and	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI	D BE	COMPLETE
(3) the establishment of a process for appeal for the resolution of any disagreement over the planned use of a restrictive intervention.	V 500	that identifies: (1) any restrict prohibited from use (2) in a 24-hounder which staff at the rights of a client (d) If the governing restrictive interventions of client (d) If the governing restrictive interventions of client (d) If the permital (d) identify: (1) the permital (e) If restrictions (2) the individent (e) If restrictive interventions (e) If restrictive interventions (f) the design has been trained are competence to use provide written authorestrictive interventions (f) the design responsible for revisite the restrictions; and (f) the establication and the establication (f) the design responsible for the resolution (f) the design responsible for	ctive intervention that is within the facility; and our facility, the circumstances re prohibited from restricting to body allows the use of ions or if, in a 24-hour facility, lient rights specified in G.S. are allowed, the policy shall ted restrictive interventions or it dual responsible for informing rocess procedures for an increase the use of ions. For eventions are allowed for use the governing body shall ment policy that assures in bothapter 27E, Section .0100, in ation of an individual, who individual to be in total of 24 hours in the time limits specified in 10A (10)(E); in ation of an individual to be in the use of the u	V 500			

Division of Health Service Regulation STATE FORM

6899 WYSV11 If continuation sheet 6 of 8

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED	
		MHL042-076	B. WING		08/	13/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	STATE, ZIP CODE		
HOMECA	ARE MANAGEMENT (CORPORATION	EGORY DRIV KE RAPIDS, N			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY)	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETE DATE
V 500	Continued From pa	ge 6	V 500			
	governing body faile abuse to the Depart (DSS) affecting one The findings are: Review on 8/3/21 of a Admission - Diagnoses Hyperactivity Disord Disabilities, Seizure Syndrome, intractal epileptics, SLE (Systand Vitamin D Deficiency of the Park Park Park Park Park Park Park Park	views and interviews, the ed to report an allegation of tment of Social Services of three audited clients (#1). of Client #1's record revealed: date of 7/5/20. of Attention-Deficit der, Moderate Intellectual Disorder, Lennox-Gastaut ole without statuepile stemic Lupus Erythematosus)				
	#1/CS/QP)'s persor	d Professional (Staff				
	by the Staff #1/CS/w - The facility notes of documente #1 - "May 13, 20 #1/CS/QP] into rest purple bruise on cli leg. Staff stated she with toileting. [Staff in the office. Client state in phrases the 'pushed me on the	of handwritten notes provided QP revealed: had two handwritten pages of ed bruises observed on Client D21 Staff [#3] called [Staff groom due to observing a ent's [initals of Client #1] right e noticed while assisting client #1/CS/QP] interviewed client is not completely verbal but at '[Person #1] hit her' and bed'. [Person #1] is another in the Adult Family Living (AFL				

Division of Health Service Regulation

STATE FORM 6899 WYSV11 If continuation sheet 7 of 8

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED	
		MHL042-076	B. WING		08/	13/2021
	PROVIDER OR SUPPLIER	CORPORATION 1165 GRE	DRESS, CITY, S GORY DRIV E RAPIDS, N			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETE DATE
V 500	home." - Separate esupport staff obser arm (lower) that was bracelet. [Staff #1/6 private, but was not of the bruise." - "6/22/21 [Staff #1/6 private, but was not of the bruise." - "6/22/21 [Staff #2/2] restroom due to Date purple bruise on clie was discovered as toileting at the day not able to determine bruises. Staff express #1/CS/QP] informed documented and [Staff express with the staff express with the staff express of the staff express with the s	ntry with no date: "Day ved purple bruise on client left is covered by one gold CS/QP] spoke with client it able to determine the cause taff #1/CS/QP] was called into by Support Staff noticing a ent's buttocks and leg. Bruise staff was assisting client with program. [Staff #1/CS/QP] was ne from client the cause of the essed concern. [Staff d staff that bruises are being staff #1/CS/QP] will continue to tent further bruises or 1 the DSS Social Worker rotective Services investigation arding bruises found on Client 1] was not identified as a lative Family Living Home 1 the Staff #1/CS/QP reported: eeping a handwritten log of n Client #1 to investigate	V 500			

6899

Division of Health Service Regulation STATE FORM