	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			A. BUILDING: _			R	
		mhl095-043	B. WING			19/2021	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE			
THREE F	ORKS HOME		P JOY ROAD E, NC 28698				
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE	
V 000	INITIAL COMMEN	TS	V 000				
	completed on 11/19 NC180081) was su cited.	int and follow up survey was 9/21. The complaint (# lbstantiated. Deficiencies were sed for the following service					
		C 27G .5600C Supervised th Intellectual and					
V 114	27G .0207 Emerge	ency Plans and Supplies	V 114				
	AND SUPPLIES (a) A written fire pla area-wide disaster shall be approved b authority. (b) The plan shall b and evacuation pro posted in the facility (c) Fire and disaster shall be held at lease repeated for each s under conditions the	er drills in a 24-hour facility st quarterly and shall be shift. Drills shall be conducted at simulate fire emergencies. all have basic first aid supplies					
	Based on record re facility failed to hold each shift at least o	et as evidenced by: eview and interviews, the d fire and disaster drills on quarterly. The findings are:					
	revealed:	1 of fire and disaster drills umentation of disaster drills					

NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		A. BUILDING:			R
	mhl095-043	B. WING			19/2021
PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
FORKS HOME					
(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO 1	TION SHOULD BE	(X5) COMPLET DATE
Continued From pa	qe 1	V 114			
having been condu	cted on 1st or 2nd shifts from				
Professional #2 rev -Shifts ran 7 days o have both live-in sta day each month.	ealed: n; 7 days off but they tried to aff run drills at various times of				
27G .0209 (C) Med	ication Requirements	V 118			
REQUIREMENTS (c) Medication adm (1) Prescription or r only be administere order of a person a drugs. (2) Medications sha clients only when at client's physician. (3) Medications, inc administered only b unlicensed persons pharmacist or other privileged to prepar (4) A Medication Ad all drugs administer current. Medication recorded immediate MAR is to include th (A) client's name; (B) name, strength, (C) instructions for (D) date and time th (E) name or initials	inistration: non-prescription drugs shall ed to a client on the written uthorized by law to prescribe all be self-administered by uthorized in writing by the cluding injections, shall be by licensed persons, or by trained by a registered nurse. Hegally qualified person and e and administer medications. Iministration Record (MAR) of red to each client must be kep s administered shall be ely after administration. The ne following: and quantity of the drug; administering the drug; ne drug is administered; and				
	PROVIDER OR SUPPLIER FORKS HOME SUMMARY STA (EACH DEFICIENCY REGULATORY OR LE Continued From path having been conduction August-October 202 Interview on 11/18/2 Professional #2 rev -Shifts ran 7 days of have both live-in stath day each month. -They were not doir 27G .0209 (C) Med 10A NCAC 27G .02 REQUIREMENTS (c) Medication adm (1) Prescription or r only be administered order of a person a drugs. (2) Medications shath client's physician. (3) Medications, inclient's physician. (3) Medication Adm administered only b unlicensed persons pharmacist or other privileged to prepart (4) A Medication Add all drugs administer current. Medication recorded immediated MAR is to include th (A) client's name; (B) name, strength, (C) instructions for (D) date and time th (E) name or initials drug.	IDENTIFICATION NUMBER: mhl095-043 PROVIDER OR SUPPLIER STREET AI FORKS HOME 392 CAM SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 1 having been conducted on 1st or 2nd shifts from August-October 2021. Interview on 11/18/21 with the Qualified Professional #2 revealed: -Shifts ran 7 days on; 7 days off but they tried to have both live-in staff run drills at various times of day each month. - -They were not doing drills as they intended. 27G .0209 (C) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (c) Medication administration: (1) Prescription or non-prescription drugs shall only be administered to a client on the written order of a person authorized by law to prescribe drugs. (2) Medications shall be self-administered by clients only when authorized in writing by the client's physician. (3) Medications, including injections, shall be administered only by licensed persons, or by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer medications. (4) A Medication Administration Record (MAR) of all drugs administered to each client must be kepi current. Medications administered shall be recorded immediately after administration. The MAR is to include the following: (A) client's name; (B) name, strength, and quantity of the drug; <td< td=""><td>IDENTIFICATION NUMBER: A. BUILDING: mh1095-043 B. WING PROVIDER OR SUPPLIER STREET ADDRESS, CITY, ST SUMMARY STATEMENT OF DEFICIENCIES 392 CAMP JOY ROAD ZIONVILLE, NC 28698 IDENTIFICATION NUMBER: A. BUILDING: CORKS HOME JON CASE988 SUMMARY STATEMENT OF DEFICIENCIES ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG Continued From page 1 V 114 having been conducted on 1st or 2nd shifts from August-October 2021. V 114 Interview on 11/18/21 with the Qualified Professional #2 revealed: Shifts ran 7 days on; 7 days off but they tried to have both live-in staff run drills at various times of day each month. V 118 -They were not doing drills as they intended. V 118 27G .0209 (C) Medication Requirements V 118 10A NCAC 27G .0209 MEDICATION REQUIREMENTS V 118 (c) Medication administration: (1) Prescription or non-prescription drugs shall only be administered to a client on the written order of a person authorized by law to prescribe drugs. (2) Medications, including injections, shall be administered only by licensed persons, or by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer medications. (4) A Medication Administration Record (MAR) of all drugs administere</td><td>OF CORRECTION IDENTIFICATION NUMBER: A BUILDING: mh095-043 B. WING PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 392 CAMP JOY ROAD 2IONVILLE, NC 28698 CORKS HOME 392 CAMP JOY ROAD CONTINUE OF DEFICIENCIES ID PROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCIES ID PREVIDER OF USC IDENTIFINIS INFORMATION) PREPIX Continued From page 1 V 114 having been conducted on 1st or 2nd shifts from COSS-REPERANCED TO DEFICIENCE Sugust-October 2021. Interview on 11/18/21 with the Qualified Professional #2 revealed: Shifts ran 7 days on; 7 days off but they tried to have both live-in staff run drills at various times of day each month. </td><td>IOF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: COM mhi095-043 B. WING 11/ PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 392 CAMP JOY ROAD SUMMARY STATEMENT OF DEFICIENCIES B. WING Image: Construction of the state of the state</td></td<>	IDENTIFICATION NUMBER: A. BUILDING: mh1095-043 B. WING PROVIDER OR SUPPLIER STREET ADDRESS, CITY, ST SUMMARY STATEMENT OF DEFICIENCIES 392 CAMP JOY ROAD ZIONVILLE, NC 28698 IDENTIFICATION NUMBER: A. BUILDING: CORKS HOME JON CASE988 SUMMARY STATEMENT OF DEFICIENCIES ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG Continued From page 1 V 114 having been conducted on 1st or 2nd shifts from August-October 2021. 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WING PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 392 CAMP JOY ROAD 2IONVILLE, NC 28698 CORKS HOME 392 CAMP JOY ROAD CONTINUE OF DEFICIENCIES ID PROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCIES ID PREVIDER OF USC IDENTIFINIS INFORMATION) PREPIX Continued From page 1 V 114 having been conducted on 1st or 2nd shifts from COSS-REPERANCED TO DEFICIENCE Sugust-October 2021. Interview on 11/18/21 with the Qualified Professional #2 revealed: Shifts ran 7 days on; 7 days off but they tried to have both live-in staff run drills at various times of day each month.	IOF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: COM mhi095-043 B. WING 11/ PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 392 CAMP JOY ROAD SUMMARY STATEMENT OF DEFICIENCIES B. WING Image: Construction of the state

STATEMEN	of Health Service Re NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
AND PLAN	I OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	······		
		mhl095-043	5-043 B. WING		R 11/19/2021	
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE		
THREE F	FORKS HOME		P JOY ROAD _E, NC 28698			
			,	PROVIDER'S PLAN OF		(YE)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
V 118	Continued From pa	ige 2	V 118			
		corded and kept with the MAR appointment or consultation				
	facility failed to kee	et as evidenced by: eviews and interviews, the p MAR current affecting 2 of 3 nd Client #3). The findings				
	-Date of admission -Diagnosis - moder disability, legally bli cholesterol, hyperg -Physician ordered included: -Glimepiride 4mg ordered 8/27/21. -Vit B12 500mcg weekly ordered 8/2 -Pioglitazone 15n ordered 10/20/21.	rate intellectual/developmental nd, schizophrenia, high lycemia medication on 8/27/21 (diabetes) 1 tablet twice daily (deficiency) 1 tablet once 7/21. ng (diabetes) once daily iabetes) inject 1.8mg				
	Review on 11/17/21 revealed: -Glimepiride was dose, 10/2/21 pm d doses) -Vit B12 was initia on 10/28/21 (not 7	1 of MARs for 9/1/21-11/17/21 not initialed on 10/1/21 pm lose or 10/3/21 pm dose. (3 aled 10/1/21-10/4/21 as well as days after last dose). s not initialed on 11/17/21.				

Division of Health Service Regulation STATE FORM

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(2) MULTIPLE CONSTRUCTION . BUILDING:		E SURVEY PLETED
		mhl095-043	3 B. WING		R 11/19/2021	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
THREE F	ORKS HOME		P JOY ROAD .E, NC 28698			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 118	Continued From pa	ge 3	V 118			
	-Victoza was not	initialed on 11/17/21.				
	-Date of admission -Diagnosis - mild in disability, Cerebral -Physician ordered included: - Montelukast 10m night.	1/18/21 for Client #3 revealed: -8/3/15 tellectual/developmental Palsy, diabetes insipidus medication on 8/27/21 ng (asthma) t tablet every 50mg (supplement) 1 tablet				
	revealed: - Montelukast wa -Zinc Gluconate	I of MARs for 9/1/21-11/18/21 s not initialed on 10/8/21. was not initialed on 10/8/21.				
	-"Yes Client #1 rece	21 with Staff #1 revealed: eived all medications this ot to initial this page."				
	Professional reveal	21 with the Qualified ed: ere were gaps on the MARs.				
	medication adminis	o accurately document stration it could not be s received their medications hysician.				
V 513	27E .0101 Client Ri Alternative	ights - Least Restictive	V 513			
		01 LEAST RESTRICTIVE all provide services/supports and respectful environment.				

STATE FORM

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If continuation sheet 4 of 12

STATEMEN	of Health Service Re TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: mhl095-043		CONSTRUCTION	(X3) DATE SURVEY COMPLETED R 11/19/2021
NAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, ST	ATE, ZIP CODE	
	FORKS HOME	392 CAN	IP JOY ROAD LE, NC 28698	,	
(X4) ID	SUMMARY STA			PROVIDER'S PLAN OF	CORRECTION (X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE COMPLET THE APPROPRIATE DATE
V 513	Continued From pa	age 4	V 513		
	skills that are altern self or others; (3) providing meaningful to the c (4) sharing o the client/legally res (b) The use of a re procedure designed always be accompa- insure dignity and r intervention. These (1) using the and	g coping and engagement natives to injurious behavior to choices of activities lients served/supported; and f control over decisions with sponsible person and staff. estrictive intervention d to reduce a behavior shall anied by actions designed to respect during and after the			
	Based on record re facility failed to use provide choices to meaningful to client those decisions wit audited clients (Client Record review on 1 -Date of admission -Diagnosis - moder	ate intellectual/developmental nd, schizophrenia, high	:		
	Interview on 11/17/ -"[Staff #3] won't giv	21 with Client #1 revealed: ve me nothing to eat." is brother don't walk until Staf	F		

	of Health Service Re					
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
					R	
		mhl095-043	B. WING		11/1	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
	ORKS HOME		P JOY ROAD			
	ORROTIONE	ZIONVILL	E, NC 28698	3		
(X4) ID PREFIX		TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO		(X5) COMPLETE
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPR DEFICIENCY)		DATE
V 513	Continued From pa	200 F	V 513			
V 010		ige 5	V 515			
	Wednesday.					
	-He rode the station	nary bike when not walking.				
		sh. "No point telling [Staff #3]				
	that, she won't give					
	,					
	Interview on 11/18/21 with Client #1's guardian					
	revealed: -"[Client #1] will say he couldn't wait till [Staff #1]					
	eat."	e will fix something good to				
		o walk all the time. She would				
	come into town to v					
		-Staff #3 didn't help them (Client #1 and his				
	brother) do persona	al care things like make their				
	beds.					
		n [Client #1 and his brother]				
	something to eat ev	/thing now cause that girl (Staff				
	#3) is leaving."	tining now cause that girl (Stan				
		21 with Qualified Professional				
	(QP) #1 revealed:					
		etired in April. She became from April to October mostly				
	through virtual cont					
	-Staff #1 and Staff					
		s weekly. Staff #1 was				
		sent a couple of menus but				
	would load her loca	al store grocery cart and the				
	QP #1 would check					
		ized menus to Staff #1 and				
		e supposed to print and keep				
	with their menus.	f #2] to incorporate preparing				
	, .	t #1] and his brother such as				
		ge/spam, toast while [Staff #1]				
		her clients to work."				
		uggested substitutes and said				
	to eliminate white b	oread, white rice.				
	ealth Service Regulation					
ATE FOR	N //		6899	7191111	16 41	tion sheet 6 o

Е STATE FORM

STATEMEN	of Health Service Re IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
AND PLAN	OF CORRECTION	IDENTIFICATION NOMBER.	A. BUILDING:			
		mhl095-043	hl095-043 B. WING		R 11/19/2021	
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
THREE FORKS HOME		IP JOY ROAD LE, NC 28698				
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C	CORRECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC)	HE APPROPRIATE	COMPLET DATE
V 513	Continued From pa	ige 6	V 513			
	times. I would then they were eating an like a balanced mea- She would go to fa twice monthly. QP would observe whe -"I counselled [Staff corrective action." -"In August, Client # unusually high and #1] went to the hos doctor recommend gave a list of foods -QP #1 talked to St June 2,9 and 10, 20 August 2,4,7 and 10 texts or emails.	acility on weekends to observe #2 worked next door and an she could. f #3] but had no formal #1's blood sugar level went up told staff to call 911. [Client pital. The follow up with ed exercise, drink water and				
	-She only became (2021. She was the -"Four years ago wa and provide menus	QP in this facility in October 3rd QP this year. e had a nutritionist come in for diabetics but don't know o cian referral/consult since	F			
	September regardin Client #1 and his br and needed more to -[Staff #3] is leaving	g. She gave notice early				
	November." -Staff #3 only had 1 should have been r October."	ate being the end of disciplinary action. "There nore but I just came on in				
vision of H		est she could being remote. I mes because I was next door				

STATEME	of Health Service Re NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	СОМ	E SURVEY PLETED
		mhl095-043	B. WING			R 19/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
THREE I	FORKS HOME		P JOY ROAD .E, NC 28698			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
V 513	Continued From pa	ge 7	V 513			
	groceries." -"[The Director] and supervision 8/5/21.' -"I have seen her m guys what they ate. -"I saw her twice a direct care at sister -"We were getting a come in but then go -"I had created a w sent to [The Directo submitted her resig -The group home a (mall), picnics, care	enus improve. I would ask the She was getting better." week but was still working facility." a referral for a dietician to ot [Staff #3]'s resignation." ritten disciplinary action and or] just before [Staff #3] nation." ctivities included walks/hikes shows, civil war reenactment, ghts, scavenger hunts, out to				
V 536	Int.	ghts - Training on Alt to Rest.	V 536			
	practices that emph to restrictive interver (b) Prior to providir disabilities, staff ince employees, student demonstrate compe completing training other strategies for which the likelihood or injury to a persor property damage is (c) Provider agence	D RESTRICTIVE mplement policies and nasize the use of alternatives entions. In g services to people with duding service providers, its or volunteers, shall etence by successfully in communication skills and creating an environment in of imminent danger of abuse in with disabilities or others or				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (M) PROVIDERSUPPLERCUA IDENTIFICATION NUMBER: (A) NULTIFIE CONSTRUCTION A BUILDING: (A) DATE SUM A BUILDING: (A) DATE SUM COMPLET NAME OF PROVIDER OR SUPPLER STREET ADDRESS, CITY, STATE, 2P CODE R 11/19/24 NAME OF PROVIDER OR SUPPLER STREET ADDRESS, CITY, STATE, 2P CODE THREE FORKS HOME 322 CAMP JOY ROAD ZIONVILLE, NC 26698 CAMP DF COMPLET RECEIPTORY BALS THE PRECEIPED BY FULL TAG PRETX RECULATORY OR LSC IDENTIFYING INFORMATION) V 538 Continued From page 8 V 536 Continued From page 9 V 536 Continued From page 9 V 536 Continued From page 9 V 536 Control 0 the training must be completed by each service provider periodically (Iminimum annually). (f) Content of the training that the service provider wishes to employ must be approved by the Division of MI/DD/SAS pursuant to Paragraph (g) of this Rule. (g) Staff shall demonstrate competence in the following core arereas: (harrow 10 the file (To 10 the p	Division	of Health Service Re	aulation			FORM	APPROVED
Imbios-043 B. WING	STATEMEN	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			COM	PLETED
382 CAMP JOY ROAD ZION/ULE, KO 28893 CMUE PROVIDER'S PLAN OF CORRECTION OF CORRECTION SHOULD BE PRECEDED BY FULL REGULTORY OR LSCIDENTIFYING INFORMATION) PREFIX CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY CONTRACT OF DEFICIENCY MUST BE PRECEDED BY FULL REGULTORY OR LSCIDENTIFYING INFORMATION) D PREFIX CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY V 536 Compliance and demonstrate they acted on data gathered. (d) The training shall be competency-based, include measurable learning objectives, measurable learning objectives and measurable methods to determine passing or failing the course. (e) Formal refresher training must be completed by each service provider periodically (minimum annually). (f) Content of the training that the service provider periodically (minimum annually). (g) Staff shall demonstrate competence in the following core areas: (1) Knowledge and understanding of the people being served; (2) recognizing and interpreting human behavior; (3) recognizing the effect of internal and external strategies for building positive relationships with persons with disabilities; (5) recognizing the importance of and assisting in the person's involvement in making decisions about their life; (7) sslit in assessing individual risk for (7)			mhl095-043	B. WING		R 11/19/2021	
Intel PORKS HOME ZIONVILLE, NC 28698 (X4) [D] PREFIX TAG Isource and set of the preceded by Full REGULATORY OR LISC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) CC V 536 Continued From page 8 V 536 CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) CC V 537 Continued From page 8 V 536 CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) CC V 538 Continued From page 8 V 536 CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) CC V 539 Continued From page 8 V 536 CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) CC V 539 Continued From page 8 V 536 CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) CROSS-REFERENCED TO THE APPROPRIATE CC (1) The training shall be completency-based, include measurable learning objectives and measurable methods to determine passing of failing the course. (e) Formal refresher training must be completed by each service provider periodically (minimum annually). (f) Content of the training that the service provider wishes to employ must be approved by the Division of MH/DD/SAS pursuant to Paragraph (g) of this Rule. (g) Staff shall demonstrate competence in the following core areas: (f) In knowledge and understanding of the people being served; (2) recognizing the effect of internal and organizational factors that may aff	NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
PRÉFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PRÉFIX TAG (EACH DEFICIENCY TON ISST DENTIFYING INFORMATION) CACH DEFICIENCY	THREE F	ORKS HOME					
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH DERICENCY AUST BE PRECEDED BY FULL TAG CONSERCEFERENCE TO THE APPROPRIATE DEFICIENCY) C V 536 Continued From page 8 V 536 V 536 (d) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (e) Formal refresher training must be completed by each service provider periodically (minimum annually). (f) Content of the training that the service provider wishes to employ must be approved by the Division of MH/DD/SAS pursuant to Paragraph (g) of this Rule. (g) Staff shall demonstrate competence in the following core areas: (1) Knowledge and understanding of the people being served; (2) recognizing the effect of internal and external stressors that may affect people with disabilities; (f) (d) Strategies for building positive relationships with persons with disabilities; (f) (f) recognizing the importance of and assisting in the person's involvement in making decisions about their life; (f)	(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORR	ECTION	(X5)
 compliance and demonstrate they acted on data gathered. (d) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (e) Formal refresher training must be completed by each service provider periodically (minimum annually). (f) Content of the training that the service provider wishes to employ must be approved by the Division of MH/DD/SAS pursuant to Paragraph (g) of this Rule. (g) Staff shall demonstrate competence in the following core areas: (1) knowledge and understanding of the people being served; (2) recognizing the effect of internal and external stressors that may affect people with disabilities; (4) strategies for building positive relationships with persons with disabilities; (5) recognizing the importance of and assisting in the person's involvement in making decisions about their life; (7) skills in assessing individual risk for 	PREFIX				CROSS-REFERENCED TO THE AF		COMPLETE DATE
gathered. (d) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (e) Formal refresher training must be completed by each service provider periodically (minimum annually). (f) Content of the training that the service provider wishes to employ must be approved by the Division of MH/DD/SAS pursuant to Paragraph (g) of this Rule. (g) Staff shall demonstrate competence in the following core areas: (1) knowledge and understanding of the people being served; (2) recognizing and interpreting human behavior; (3) recognizing the effect of internal and external stressors that may affect people with disabilities; (4) strategies for building positive relationships with persons with disabilities; (5) recognizing cultural, environmental and organizational factors that may affect people with disabilities; (6) recognizing the importance of and assisting in the person's involvement in making decisions about their life; (7) skills in assessing individual risk for	V 536	Continued From pa	ge 8	V 536			
 (8) communication strategies for defusing and de-escalating potentially dangerous behavior; and (9) positive behavioral supports (providing means for people with disabilities to choose 		gathered. (d) The training sha include measurable measurable testing behavior) on those methods to determi course. (e) Formal refreshe by each service pro annually). (f) Content of the tr provider wishes to e the Division of MH/I Paragraph (g) of thi (g) Staff shall demo following core areas (1) knowledg people being served (2) recognizin behavior; (3) recognizin external stressors to disabilities; (4) strategiess relationships with po (5) recognizin organizational factor disabilities; (6) recognizin assisting in the pers decisions about the (7) skills in as escalating behavior (8) communic and de-escalating p and (9) positive bo means for people w	Il be competency-based, e learning objectives, (written and by observation of objectives and measurable ne passing or failing the er training must be completed vider periodically (minimum raining that the service employ must be approved by DD/SAS pursuant to s Rule. onstrate competence in the s: e and understanding of the d; ng and interpreting human ng the effect of internal and hat may affect people with for building positive ersons with disabilities; ng cultural, environmental and rs that may affect people with ag the importance of and son's involvement in making ir life; ssessing individual risk for ; cation strategies for defusing potentially dangerous behavior; ehavioral supports (providing				

Division	of Health Service Re	equilation			FORM	APPROVED
STATEMEI	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED
		mh1095-043	B. WING		R 11/19/2021	
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE		
	FORKS HOME	392 CAM	P JOY ROAD			
		ZIONVILI	E, NC 28698			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETE DATE
V 536	Continued From pa	ge 9	V 536			
Division of F	behaviors which are (h) Service provide documentation of in at least three years (1) Documen (A) who partic outcomes (pass/fail (B) when and (C) instructor (2) The Divisi review/request this (i) Instructor Qualif Requirements: (1) Trainers s by scoring 100% or aimed at preventing need for restrictive (2) Trainers s by scoring a passin instructor training p (3) The training competency-based objectives, measuration observation of behave measurable methods failing the course. (4) The contest service provider plat approved by the Div to Subparagraph (i) (5) Acceptable shall include but are (A) understan (B) methods course; (C) methods performance; and	rs shall maintain itial and refresher training for tation shall include: ipated in the training and the); where they attended; and 's name; fon of MH/DD/SAS may documentation at any time. ications and Training shall demonstrate competence testing in a training program g, reducing and eliminating the interventions. shall demonstrate competence g grade on testing in an rogram. ng shall be , include measurable learning able testing (written and by avior) on those objectives and ds to determine passing or ent of the instructor training the ins to employ shall be vision of MH/DD/SAS pursuant				

Division of Health Service Regulation STATE FORM

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If continuation sheet 10 of 12

	of Health Service Re IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:			
		mhl095-043	B. WING			R 19/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
THREE F	ORKS HOME		P JOY ROAD			
			E, NC 28698			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
V 536	Continued From pa	ige 10	V 536			
	teaching a training reducing and elimin interventions at lease review by the coach (7) Trainers as aimed at preventing need for restrictive annually. (8) Trainers as instructor training a (j) Service provided documentation of in training for at least (1) Docum (A) who partice outcomes (pass/fail (B) when and (C) instructor (2) The Divis request and review (k) Qualifications of (1) Coaches requirements as a to (2) Coaches the course which is (3) Coaches competence by cor- train-the-trainer inst	shall teach a training program g, reducing and eliminating the interventions at least once shall complete a refresher it least every two years. rs shall maintain nitial and refresher instructor three years. mentation shall include: cipated in the training and the l); d where attended; and 's name. ion of MH/DD/SAS may this documentation any time. of Coaches: shall meet all preparation trainer. shall teach at least three times being coached. shall demonstrate npletion of coaching or				
	This Rule is not me	et as evidenced by:				
ision of H	ealth Service Regulation	-	P			1

IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			(X3) DATE SU COMPLE	
OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING:		COM	PLETED
	mhl095-043	B. WING		R 11/19/2021	
PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, ST	ATE, ZIP CODE		
ORKS HOME					
	TEMENT OF DEFICIENCIES	ID			(X5)
		PREFIX TAG	CROSS-REFERENCED TO TH	HE APPROPRIATE	COMPLET DATE
Continued From pa	ge 11	V 536			
interviews, the facil completed training intervention annual #1 and Staff #3). T Record review on 1 -Date of hire- 1/15/ -NCI+ was complet expired 9/14/21. -No annual or upda prior to expiration. Record review on 1 -Date of hire- 10/26 -NCI+ was complet expired 11/2/21. -No annual or upda prior to expiration. Interview on 11/19/2 Professional #2 rev -She was aware bo compliance and bo	ity failed to ensure that all staff in alternatives to restrictive ly for 2 of 4 current staff (Staff 'he findings are: 1/18/21 for Staff #1 revealed: 19 as direct support staff. ed on 9/14/20 and therefore ted training was completed 1/18/21 for Staff #3 revealed: 5/20 as direct support staff. ed on 11/2/20 and therefore ted training was completed 21 with the Qualified realed: th staff were out of th were scheduled for NCI+				
F	OF CORRECTION PROVIDER OR SUPPLIER FORKS HOME SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From pa Based on personne interviews, the facil completed training intervention annual #1 and Staff #3). T Record review on 1 -Date of hire- 1/15/ -NCI+ was complet expired 9/14/21. -No annual or upda prior to expiration. Record review on 1 -Date of hire- 10/26 -NCI+ was complet expired 11/2/21. -No annual or upda prior to expiration. Interview on 11/19/2 Professional #2 rev -She was aware bo compliance and bo	OF CORRECTION IDENTIFICATION NUMBER: mhl095-043 PROVIDER OR SUPPLIER STREET ADI ORKS HOME 392 CAMF SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 11 Based on personnel record review and staff interviews, the facility failed to ensure that all staff completed training in alternatives to restrictive intervention annually for 2 of 4 current staff (Staff #1 and Staff #3). The findings are: Record review on 11/18/21 for Staff #1 revealed: -Date of hire- 1/15/19 as direct support staff. -NCI+ was completed on 9/14/20 and therefore expired 9/14/21. -No annual or updated training was completed prior to expiration. Record review on 11/18/21 for Staff #3 revealed: -Date of hire- 10/26/20 as direct support staff. -NCI+ was completed on 11/12/20 and therefore expired 11/2/21. -No annual or updated training was completed prior to expiration. Record review on 11/18/21 for Staff #3 revealed: -Date of hire- 10/26/20 as direct support staff. -NCI+ was completed on 11/2/20 and therefore expired 11/2/21. -No annual or updated training was completed	OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING:	OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: mhl095-043 B. WING PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE SUMMARY STATEMENT OF DEFICIENCIES 392 CAMP JOY ROAD ZIONVILLE, NC 28698 ID PROVIDEROR VOLUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) V 536 Continued From page 11 V 536 Continued From page 11 V 536 Based on personnel record review and staff interviews, the facility failed to ensure that all staff completed training in alternatives to restrictive intervention annually for 2 of 4 current staff (Staff #1 and Staff #3). The findings are: Record review on 11/18/21 for Staff #1 revealed: -Date of hire- 1/15/19 as direct support staff. -NCI+ was completed on 9/14/20 and therefore expired 9/14/21. -No annual or updated training was completed prior to expiration. Record review on 11/18/21 for Staff #3 revealed: -Date of hire- 10/26/20 as direct support staff. -NCI+ was completed on 11/2/20 and therefore expired 11/2/21. -No annual or updated training was completed prior to expiration. Interview on 11/19/21 with the Qualified Professional #2 revealed: -She was aware both staff were out of compliance and both were scheduled for NCI+	OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: