Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		A. BUILDING: _				
		MHL0411115	B. WING		06/29/	/2022
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
J GEE'S H	OUSE		IONES ROAD			
			ORO, NC 2740			
(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 000	INITIAL COMMENTS		V 000			
	An annual and complaint survey was completed on June 29, 2022. The complaint was unsubstantiated (Intake #NC00189701). A deficiency was cited.					
	This facility is licensed for the following survey category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities. This facility is licensed for 3 and currently has a census of 3. The survey sample consisted of audits of 3 current clients,					
V 112	27G .0205 (C-D) Assessment/Treatme	nt/Habilitation Plan	V 112			
	10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (c) The plan shall be developed based on the					
	legally responsible pe	_				
	achieved by provision projected date of achi (2) strategies;	ievement;				
	annually in consultation responsible person or	view of the plan at least on with the client or legally r 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.					

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND I EAN OF CONNECTION IDENTIFICATION NOWIDER.		A. BUILDING:	A. BUILDING:		IED	
		MHL0411115	B. WING	B. WING		/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	ATE, ZIP CODE		
		2006 OLI	JONES ROAD			
J GEE'S H	OUSE	GREENS	BORO, NC 274	06		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT	TION	(X5)
PREFIX TAG	, -	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)		COMPLETE DATE
V 112	Continued From page	e 1	V 112			
		•				
	This Dula is not mot	as avidenced by:				
	This Rule is not met as evidenced by:					
	Based on record reviews and interviews, 1 of 2 Former Staff (FS #1) failed to implement goals					
	and strategies of 1 of 3 client's (#1) Individual					
	Behavior Support Pla	n (IBSP). The findings are:				
	Davious on 6/20/22 of	FS #1's record revealed:				
	-A hire date of 4/29/2					
	-A separation date of					
	-A job description of F					
		behavior plan training for				
	client #1 noted "the g	• •				
		edications, client's target				
	behaviors, historical in	· · · · · · · · · · · · · · · · · · ·				
	preventive and interve	•				
	documentation of collective data and behaviors					
	and training strategies for relation/problem					
	solving."					
		umentation, data tracking				
	and data input for clie	ent #1 dated 5/13/21				
	Di					
		client #1's record revealed:				
	-An admission date o					
		ellectual Disability, Bipolar				
		ise Specified, Attention				
	Deficit Hyperactivity [
	Constipation and Iron	•				
		d 9/1/15 noting "aged out of				
		her certificate from an				
	education center and	transitioned to [a local day				
	program], previously	hospitalized due to				

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Division of	<u>of Health Service Regu</u>	lation				
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:	A. BUILDING:			
			- I			
		D WING				
		MHL0411115	B. WING		06/29/2022	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE. ZIP CODE		
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J GEE'S H	OUSE		D JONES ROAD	•		
		GREENS	BORO, NC 2740	J6		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(- /	
PREFIX			PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE		ΓE
TAG	NEGOLATORT OR I	130 IDENTIF TING INFORMATION)	TAG	DEFICIENCY)	MAIL 5/112	
				,		-
V 112	Continued From page	2	V 112			
		medications, refusing to				
		s and barricading herself in				
		istory of stealing, has a				
	history of verbal and p					
	engaged in severe pr					
	attempted to run into					
	•	nistory of non-compliance,				
	accusing other of doing things to her, a history of					
	hoarding food and inserting herself into other's					
	business."					
	-A treatment plan dated 5/1/21 noting "will remain					
	on task with an					
	activity until complete	, will manager her anger				
	appropriately, will					
	participate appropriat	ely in a leisure/exercise				
	activity of her choice					
	3 times per week, will	improve her independence				
	with completing					
	daily chores, will be a	ble to properly care for her				
	clothes, will					
	complete independen	ce with daily				
	hygiene/grooming, will reduce					
	the number of elopements to zero and will have					
	24-hour					
	supervision in order to maintain her placement."					
	-An IBSP dated 3/14/	22 noted "target behaviors				
	included eloping, noncompliance, physical					
	aggression towards o	thers, aggression to				
	property by damaging	g, throwing or breaking or				
	attempting to damage	e objects, verbal aggression,				
	accusing staff/others	of doing something to her,				
		d and historical behaviors of				
	inserting herself into					
		s included decreasing her				
	eloping, decreasing h					ļ
		ical and verbal aggression,				
	decreasing accusing					

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pockets when asked and decreasing hoarding of items ...intervention strategies included ...if she elopes or is physically aggressive and does not

STATE FORM 6899 If continuation sheet 3 of 7 250J11

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DIVISION	n Health Service Negu	ialion				
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN C	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COMPLETED	
	********		B. WING			
		MHL0411115	B. WING		06/2	9/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
			JONES ROAD			
J GEE'S H	OUSE		BORO, NC 2740	06		
	OLIMANA DV OT		<u> </u>		N.	
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
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				DEFICIENCY)		
V 112	Continued From page	. 2	V 112			
V 112	Continued From page	3	V 112			
	want to calm down, ca	all 911 for assistance, use				
	blocking techniques to	o protect self and others,				
	move objects and pro	ompt others to get out of her				
		ely to damage them"				
	,	, 3				
	Interview on 6/28/22	with FS #1 revealed:				
	-Had recently quit her	r job at the group home				
	(5/31/22)					
	-Had been trained on	client #1's IBSP				
	-"With [client #1] it's like she expects staff to do					
	everything for her. The last few days, she					
	punched me in the fa	ce, continued to elope and				
	she doesn't like to list	ten to the staff. It's hard				
	working with her and	working there. She always				
	_	up and leaves, and then I				
	_	he police all the time"				
		raining was on what to do				
	when client #1 eloped					
	-	the Licensed Psychologist]				
		everything we are supposed				
		on to take and it still does not				
		sten and even when you try				
		ep prompting her, I have to				
	keep talking to her. [Client #1] will say she is sorry and then does the same thing"					
		-Worked on 5/31/22 when client #1 eloped from				
		when offent #1 cloped from				
	the facility.					
	-"I just told her if she left, I was calling the police. That's all I did. She doesn't listenI did not ask					
		ave other clients to worry				
	about"	ave office onerite to worry				
		#1's IBSP with asking her to				
		oal prompts or used blocking				
	techniques					
	Observation and into	rview on 6/20/22 with client				
	#1 at approximately 1					
	- Stated she had grits					
	-i lei eyes are wide of	-Her eyes are wide open and were not able to				

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	of Health Service Regu		1			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		MHL0411115	B. WING		06/29/2022	
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NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STA	TE, ZIP CODE		
J GEE'S H	IOUSE		D JONES ROAD			
0 022 0 11	.0001	GREENS	BORO, NC 2740	6		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	()	
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TAG	REGULATORT OR I	230 IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	NATE	
				·		
V 112	Continued From page	e 4	V 112			
	Mos drasling on left	aids of face, her				
	 -Was drooling on left arms/hands had unco 					
	_	aff were nice and the food				
	was good.,	from the group home				
	-"Go nowhere."	-Admitted to running from the group home				
	-Shook head yes to sitting in the street and the					
	police coming out to the facility.					
	-"Not safe (in the street)."					
	-Shook her head to the police returning her to the					
	facilityStated she did not know why she runs away.					
	-Started yelling to the House Manger " Come					
	here. Come here."					
	-No other information was able to be gathered as					
	client #1 got up with assistance and went to her					
	room.					
	100111.					
	Reviews on 6/29/22 of	of the LP Specialized				
		Service Notes, dated				
	6/1/22 and 6/7/22, for	•				
	-"6/1/22: Description of Intervention/Activity:					
	Received a call from [client #1] Care Coordinator.					
	She said [client #1] eloped last evening (5/31/22)					
		and someone in the community found her. She				
	was drooling, complaining about her stomach					
		to go to the hospital. There				
	•	and the woman let her sit in				
	the air-conditioned ca	ır and gave her water. She				
	called 911 for assista	nce and the woman noted				
	[client #1] was shakin	g and EMS transported				
	[client #1] to the hosp	-				
	community said they	had seen her walking alone				
	in the community befo					
	-"Plan of Action: will r	neet with [client #1] and/or				
	her team approximate	ely monthly to review				
progress and status. Will modify the hebayion		1				

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support plan as needed. Will train staff as requested and needed. Will summarize and

analyze behavior data monthly ..."

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
THE PLANT OF THE PROPERTY OF T		A. BUILDING:		COMPLET	IED	
		MHL0411115	B. WING		06/29/2022	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
J GEE'S H	IOUSE	2006 OLD	JONES ROAD			
0 022 0 1		GREENSB	ORO, NC 2740	06		
(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 CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETE DATE
V 112	Continued From page	e 5	V 112			
	-"6/7/22: Description Participate in a confe the QP, The Director, the Guardian Repres behaviors, intervention last team meeting"	of Intervention Activity: rence call with facility staff, the Care Coordinator and entative to discuss ons and updates since the with the Licensed				
Psychologist (LP) revealed: -Was scheduled to retrain all the staff at the facility on 6/30/22 on client #1's IBSP -Had completed training with the staff on 6/7/22		train all the staff at the client #1's IBSP				
	Further interview on 6/29/22 with the LP revealed: -Would not be conducting the training on 6/30/22 -Client #1 was admitted to the hospital on 6/29/22 -The hospital was looking at placing her in a skilled nursing facility. Interview on 6/20/22 with the Qualified Professional revealed: -FS #1 was terminated on 5/31/22 -"She was not a good fit with working with [client #1]. She had been trained several times on [client #1]'s IBSPshe would let [client #1] run off and then call the police. She knew her triggers and what behaviors to look for"					
	-All staff had been tra -Terminated FS #1 or -"She called [the Hou #1] had eloped. She I -Was only recently m Management Entity/N (LME/MCO)'s monito EMS were called on 8	se Manager] and said [client had to be told to call 911" ade aware by the Local Managed Care Organization ring team that the police and 5/31/22" ding FS #1 just let her elope lid not use any of the				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C			E SURVEY PLETED	
		MHL0411115	B. WING		06	6/29/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATI	E, ZIP CODE		
J GEE'S H	HOUSE		.D JONES ROAD SBORO, NC 27406	3		
(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 C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
V 112	-In the future, she wo undated training on a understood what stra Further interview on 6 revealed: -Client #1 was taken -Was assessed and p cleared"The social worker a admitted. She is look facility for [client #1]. complete her discharge worker stated we wer	ould ensure all staff have ny clients' IBSP and tegies to use. 6/29/22 with the Director to the hospital on 6/28/22 ohysically client #1 was	V 112			

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