STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		MHL096-277	B. WING		07/0	8/2022
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
DE	EE EVTENDED ING	201 WIND	SOR CREEK	( PARKWAY		
RENU LI	FE EXTENDED INC	GOLDSBO	DRO, NC 27	530		
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETE DATE		
V 000	INITIAL COMMENT	rs .	V 000			
	on July 8, 2022. Or unsubstantiated (int complaint was subs #NC00190564). Do This facility is licens category: 10A NCA Living for Adults wit This facility is licens	take #NC00188961) and one stantiated (intake eficiencies were cited.  sed for the following service NC 27G .5600C Supervised the Developmental Disabilities.  sed for 24 and currently has a survey sample consisted of				
V 118	27G .0209 (C) Med	ication Requirements	V 118			
	only be administered order of a person andrugs.  (2) Medications shat clients only when an client's physician.  (3) Medications, included administered only bunlicensed persons pharmacist or other privileged to prepare (4) A Medication Administered only bunlicensed persons pharmacist or other privileged to prepare (4) A Medication Administered only bundled administer current. Medication recorded immediate MAR is to include the (A) client's name;  (B) name, strength,	inistration: non-prescription drugs shall ad 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 y licensed persons, or by trained by a registered nurse, a legally qualified person and e and administer medications. Ininistration Record (MAR) of administered shall be ally after administration. The				

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

(X6) DATE TITLE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		MHL096-277	B. WING		07/0	8/2022
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
RENU LI	FE EXTENDED INC		SOR CREEK DRO, NC 27			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECTI	ON	(X5)
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)		COMPLETE DATE
V 118	Continued From pa	ge 1	V 118			
	(E) name or initials drug. (5) Client requests checks shall be red	ne drug is administered; and of person administering the for medication changes or corded and kept with the MAR appointment or consultation				
	interviews the facili medications as ord to keep MARS curr clients (#5, #6 and Review on 6/21/22 - 24 year old female - Diagnoses include (TBI), Bipolar I Disc and Polysubstance - Signed Physician bupropion (antidep 1/2 tablet daily for 7 daily; dated 10/08/2 D3 deficiency) 125 daily; and signed 5/4	views, observations and ty failed to administer ered by a physician and failed ent affecting 3 of 3 audited #15) The findings are:  of client #5's record revealed: e admitted 7/26/21. ed Traumatic Brain Injury order, Opiate Use Disorder, Use Disorder. s order dated 12/30/21 for ressant) 75 milligrams (mg) 7 days then increase to 1 tablet 21 for cholecalciferol (vitamin micrograms (mcg) 1 tablet /20/22 for ciclopirox 8% ) apply to affected toenails, on				
	June 2022 revealed - Transcription for the	oupropion 75 mg 1/2 tablet aff initials documented				

Division of Health Service Regulation

STATE FORM BBK611 If continuation sheet 2 of 32

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		MHL096-277	B. WING		07/0	8/2022
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE	·	
RENU L	FE EXTENDED INC		SOR CREEP DRO, NC 27	C PARKWAY 530		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / 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 118	- Transcription for 68:00 am; blank for 6"no supply of medic - No transcription for at 8:00 am on the Nand 6/02/22 with no Observation on 6/2 am of client #5's me - Bupropion 75 mg 6/22/22 Cholecalciferol 12 dispensed 6/22/22 Ciclopirox 8% solo on skin and nail bedon buring interview on took her medication and had never miss Review on 6/21/22 - 46 year old male a - Diagnoses include Disorder, Depression Disorder, Depression Disorder, Seizure Migraines Signed Physician' 3/10/22 for aspirin (daily, cetirizine (ant magnesium (dietary at bedtime; signed (digestion) 2 every for Ultram (pain relians needed (prn), signed 1 tablet three times Review on 6/21/22 June 2022 revealed - Transcription for a	cholecalciferol 1 tablet daily at 6/11/22 with documentation of cation." or ciclopirox 8% solution daily May MAR; blanks for 6/01/22 of documented explanation.  2/22 at approximately 10:45 edications on hand revealed: take 1 tablet daily, dispensed take 1 tablet daily, dispensed daily, dispensed 6/01/22.  6/22/22 client #5 stated she as daily with staff assistance sed any.  of client #6's record revealed: admitted 2/06/07. ed TBI, Major Neurocognitive on, Unspecified Mood (Affect) Disorder, and Chronic sorders dated 2/10/22 and (pain relief) 81 mg 1 tablet daily, y supplement) 400 mg 1 tablet ihistamine) 5 mg 1 tablet daily, y supplement) 400 mg 1 tablet 3/02/22 for probiotic capsules morning; and signed 3/31/22 eff) 50 mg 1 tablet twice daily gned 5/18/22 for Ultram 50 mg daily as needed.  of client #6's MARs for April -	V 118			

Division of Health Service Regulation

STATE FORM BBK611 If continuation sheet 3 of 32

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		MHL096-277	B. WING		07/0	8/2022
	PROVIDER OR SUPPLIER FE EXTENDED INC	201 WIND	ORESS, CITY, S SOR CREEK ORO, NC 27			
(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 SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
V 118	morning at 8:00 am with no documented - Transcription for commented - Transcription on 6/22 am of client #6's means of client	pation.  robiotic capsules 2 every ; blanks for 4/09/22 - 4/14/22 d explanation. etirizine 5 mg 1 tablet daily at hentation of administration  ragnesium 400 mg 1 tablet at the documentation of .  or Ultram 50 mg on the April ption for Ultram 50 mg 1 tablet in on the May 2022 MAR.  2/22 at approximately 11:05 edications on hand revealed: aspirin 81 mg with expiration or etirizine 10 mg vith expirati	V 118			

Division of Health Service Regulation

STATE FORM BBK611 If continuation sheet 4 of 32

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	MHL096-277	B. WING		07/0	8/2022
NAME OF PROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, S	STATE, ZIP CODE		
RENU LIFE EXTENDED INC		SOR CREEK ORO, NC 27:			
PREFIX (EACH DEFICIENCY MU	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
June 2022 revealed: - Transcription for Fossweekly before breakfast blanks for 4/25/22, 5/0 6/13/22, and 6/20/22 a medicine" documentation once in June (Monday (Monday 5/30/22) and (Monday 4/04/22, Monday 4	client #15's MARs for April - camax 70 mg 1 tablet list or other medications with 22/22, 5/09/22, 5/16/22, and "No supply of d. Fosamax was administered of 6/06/22), once in May I three times in April linday 4/11/22, and Monday  22 at approximately 11:20 dications on hand revealed: ke Thursday at 7:00 am"  22/22 client #15 stated he daily with staff assistance in time."  22/22 staff #3 stated client gnesium were purchased administered one cetirizine he MAR. She did not the cetirizine and list ordered by the Physician.  6/21/22, 6/22/22 and 6/27/22 ordinator (RCC) stated: were delivered from the Nednesday afternoons and for administration. In medications as ordered. In the estrength of client #6's lizine and magnesium were	V 118			

Division of Health Service Regulation

STATE FORM BBK611 If continuation sheet 5 of 32

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			D. WING			
		MHL096-277	B. WING		07/0	8/2022
NAME OF F	PROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, S	STATE, ZIP CODE		
DENILLI	FE EXTENDED INC	201 WIND:	SOR CREEK	( PARKWAY		
KLINO LII	I L LXTENDED INC	GOLDSBO	ORO, NC 27	530		
(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 APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
V 118	Continued From pa	ge 5	V 118			
	increase of her bup 1/2 tablet Client #15 took his - She would discuss to ensure compliand Due to the failure to medication adminis	accurately document tration it could not be s received their medications				
V 132	G.S. 131E-256(G) H Allegations, & Prote		V 132			
	REGISTRY  (g) Health care facil Department is notifi health care personr unknown source, w any act listed in sub (which includes: a. Neglect or abus facility or a person t as defined by G.S. as defined by G.S. b. Misappropriatio in a health care faci (b) of this section in care services as de hospice services as are being provided. c. Misappropriatio healthcare facility. d. Diversion of dru facility or to a patier e. Fraud against a	lities shall ensure that the lied of all allegations against hel, including injuries of hich appear to be related to odivision (a)(1) of this section.  The end of a resident in a healthcare to whom home care services 131E-136 or hospice services 131E-201 are being provided. In of the property of a resident illity, as defined in subsection accluding places where home of the fined by G.S. 131E-136 or a defined by G.S. 131E-201 and the property of a light by G.S. 131E-201 and the property of a light belonging to a health care not or client. In health care facility or against or whom the employee is				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		MHL096-277	B. WING		07/	08/2022
	PROVIDER OR SUPPLIER	201 WIND	DRESS, CITY, S SOR CREEK ORO, NC 275			
(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 ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
V 132	providing services). Facilities must hav acts are investigate to protect residents investigation is in prinvestigations must	e evidence that all alleged and must make every effort from harm while the rogress. The results of all be reported to the five working days of the initial	V 132			
	interviews the facilit of abuse to the Head (HCPR) of the Division Regulation within 5 former staff (#4). The Review on 6/21/22 - 46 year old male and Disorder, Depression Disorder, Seizure Di	views, observations and ty failed to report an allegation alth Care Personnel Registry sion of Health Service working days affecting 1 The findings are: of client #6's record revealed:				

Division of Health Service Regulation

STATE FORM BBK611 If continuation sheet 7 of 32

STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION	PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		A. BUILDING.			
	MHL096-277	B. WING		07/0	8/2022
NAME OF PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
RENU LIFE EXTENDED INC		SOR CREEK DRO, NC 27:			
(X4) ID SUMMARY STATEME	ENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON	(X5)
	BT BE PRECEDED BY FULL SENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)		COMPLETE DATE
V 132 Continued From page 7	7	V 132			
- He asked FS#4 to help she didn't respond quick himself in his bed His girlfriend, client #5 brought her into his room up from his feet toward body FS#4 "showed [client #5 - "I told everybody, but I told; it was humiliating; I #6 was observed to hole about 1/4 inch apart) He remembered telling Professional #2 (QP#2) - The incident happened Review on 6/21/22 of client #6 his professional #2 (QP#2) - The incident happened Review on 6/21/22 of client #6 had a bm (himself in bed and she his room and embarrass but she doesn't work her fired."  Review on 6/21/22 of F3 revealed: - Date of hire 8/02/21, tient work her fired for termination 4/2 here are given and 2/21 here entiting dated 8/05/21 here entiting dated 8/05/21 here entiting a Competent Braining a Competent Braining a Competent Braining and competent Br	p him with his bedpan, but kly enough and he soiled by the soiled by was in the hall and FS#4 m, pulled the bed sheets his head exposing his with head exposing his with head exposing his with head exposing his lean't remember who I felt about that big" (client doubt his thumb and forefinger go the Qualified about the incident. doubt while ago."  Itient #5's record revealed: mitted 7/26/21. raumatic Brain Injury r, Opiate Use Disorder, en Disorder.  2/22 client #5 stated: rifriend; (bowel movement) on (FS#4) called me over to sed him; it was [FS#4], ere anymore; she got  S#4's personnel record itle Direct Support Staff. mitted 4/10/22. 21/22. It in "Client Rights: glect & Exploitation";	V 132			

Division of Health Service Regulation

STATE FORM BBK611 If continuation sheet 8 of 32

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		MHL096-277	B. WING		07/0	8/2022
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
RENU LI	FE EXTENDED INC		SOR CREEK DRO, NC 27			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES ( 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 132	Continued From pa	ge 8	V 132			
	Abuse, Neglect and	Exploitation policies.				
	- She was not invol #6. - Facility managem what to say. - She left her job at Review on 6/21/22 revealed no docum an allegation of abu					
	During interview on 6/27/22 QP#2 stated he was notified of the incident/allegation but did not report it to any outside agency; his only role in the internal investigation was to notify client #6's designated contact person of the incident.					
	President of the factor of the was aware of by client #6. Former staff #4 di occurred and did not abuse could be ementifying HCPR of a state of the country	the allegation of abuse made d not deny the incident of seem to understand that otional or mental harm. ograms was responsible for allegations of abuse.				
	Programs stated: - The facility condu- of the allegation of - The allegation aga - FS#4 gave her 2 v - She told FS#4 not week notice.	6/27/22 the Director of cted an internal investigation abuse against FS#4. ainst FS#4 was substantiated. week notice. to return to work during the 2 tified of the allegation of				

Division of Health Service Regulation

STATE FORM BBK611 If continuation sheet 9 of 32

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING: (X3) DATE S  COMPLI				
		MHL096-277	B. WING		07/0	8/2022
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
RENU LI	FE EXTENDED INC		SOR CREEK ORO, NC 27			
(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 SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
V 132	Continued From pa	ge 9	V 132			
	abuse within 5 work	king days.				
V 291	27G .5603 Supervis	sed Living - Operations	V 291			
	six clients when the developmental disa on June 15, 2001, at than six clients at the provide services at licensed capacity. (b) Service Coording maintained between qualified profession treatment/habilitation (c) Participation of Responsible Person provided the opport relationship with he means as visits to the facility. Reports annually to the pare legally responsible Reports may be in a conference and shapping responsible Reports may be in a conference and shapping responsible Reports and the treat Activities shall be do inclusion. Choices or legal system is in safety issues become	cility shall serve no more than a clients have mental illness or bilities. Any facility licensed and providing services to more nat time, may continue to no more than the facility's nation. Coordination shall be not the facility operator and the als who are responsible for on or case management. The Family or Legally note and the facility and visits outside a shall be submitted at least and of a minor resident, or the person of an adult resident. Writing or take the form of a sall focus on the client's a peting individual goals. The seed on her/his choices, ment/habilitation plan. The seigned to foster community may be limited when the court involved or when health or one a primary concern.				
	This Rule is not me Based on record re	et as evidenced by: view and interviews the facility				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		MHL096-277 B. WING			07/0	08/2022
RENULLIFE EXTENDED INC. 201 WINI		, ,	STATE, ZIP CODE K PARKWAY 1530			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
V 291	failed to ensure that mental illness or de served. The finding Review on 6/21/22 by the Division of H (DHSR) effective 1/capacity of 24.  Review on 6/21/22 Licensure and Certistaff Census' form Care Coordinator reserved by the facilit Review on 6/22/22 addressed to the Prestended, Inc. from Mental Health Licer revealed "RE: Approximate Approximate 10A NCAC 27 the waiver will allow a capacity of 24 27G .0813, the waive (a) cannot exceed to the preserved by the facility of 24 27G .0813, the waive (a) cannot exceed the seconsideration upon During interview on facility stated the fathe waiver for 2022 for an updated waive should be requested.	t no more than six clients with velopmental disabilities were as are:  of the facility's license issued ealth Service Regulation 01/22 revealed a licensed  of the DHSR Mental Health ification Section "Client and completed by the Resident evealed 21 current clients by.  of a letter dated 6/22/21 resident of RENU Life at the Acting Chief of DHSR insure and Certification Section oval of Request for Waiver of G.5603(A) Approval of the facility to be licensed with In accordance with 10A NCAC over of Rule 10A NCAC 5603 he expiration date of the 2021 exember 31, 2021; and subject to renewal the request of the licensee."  6/22/22 the President of the cility did not request to renew in She would submit a request for increased occupancy did annually and separately sense renewal. The facility	V 291			

6899

Division of Health Service Regulation STATE FORM

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
, , , , , , , , , , , , , , , , , , , ,	01 0011112011011	BERTH 10/MIGHT 16 MBERT	A. BUILDING:	<del></del>	00.0	
		MHL096-277	B. WING		07/08/2022	
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
		201 WIND	SOR CREEK	( PARKWAY		
RENU LI	FE EXTENDED INC		DRO, NC 27			
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION S		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
V 366	Continued From pa	ge 11	V 366			
V 366	27G .0603 Incident Response Requirments		V 366			
	implement written presponse to level I, shall require the pro (1) attending of individuals involv (2) determining (3) developing measures according timeframes not to equivers (4) developing to prevent similar in specified timeframe (5) assigning for implementation preventive measures (6) adhering set forth in G.S. 75, 42 CFR Parts 2 and 164; and (7) maintaining Subparagraphs (a) (b) In addition to the Paragraph (a) of this shall address incide regulations in 42 CI (c) In addition to the Paragraph (a) of this providers, excluding develop and implementation and implementation in their response to a while the provider is or while the client is	BIREMENTS FOR B PROVIDERS B providers shall develop and policies governing their II or III incidents. The policies povider to respond by: to the health and safety needs red in the incident; and the cause of the incident; and implementing corrective g to provider specified exceed 45 days; and implementing measures recidents according to provider responds to exceed 45 days; because of the corrections and				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BOILDING.			
		MHL096-277	B. WING		07/0	8/2022
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
RENU LI	FE EXTENDED INC		SOR CREEK			
	0.18.44.574.074		ORO, NC 27			
(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 SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
V 366	Continued From pa	ge 12	V 366			
	by: (1) immediate by: (A) obtaining a (C) certifying (D) transferrir review team; (2) convening review team within internal review team who were not involv were not responsib with direct professic services at the time review team shall c follows: (A) review the determine the facts and make recommo occurrence of future (B) gather otl (C) issue writ within five working o preliminary findings LME in whose catcl located and to the L if different; and (D) issue a fin owner within three of final report shall be catchment area the LME where the clie final written report so identified by the inte include all public do incident, and shall r minimizing the occur	the client record; photocopy; the copy's completeness; and ag the copy to an internal 24 hours of the incident. The a shall consist of individuals are in the incident and who le for the client's direct care or onal oversight of the client's of the incident. The internal complete all of the activities as a copy of the client record to and causes of the incident endations for minimizing the				

6899

Division of Health Service Regulation STATE FORM

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL096-277	B. WING		07/0	8/2022
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE	1 0110	012022
	FE EXTENDED INC		SOR CREEK	,		
INCINO LI			ORO, NC 27			1
(X4) ID PREFIX TAG	(EACH DEFICIENCY	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 366	available within thre LME may give the p three months to sul (3) immediat (A) the LME r area where the ser Rule .0604; (B) the LME different; (C) the provice for maintaining and treatment plan, if di provider; (D) the Depar (E) the client applicable; and	ee months of the incident, the provider an extension of up to bmit the final report; and ely notifying the following: responsible for the catchment vices are provided pursuant to where the client resides, if der agency with responsibility I updating the client's ifferent from the reporting	V 366			
	Based on record rethe facility failed to governing their responsible. The findings are:  Review on 6/27/22 Reporting" policy et 6/25/18 revealed: - " Level II and I using the I.R.I.S. sylusing the II.S. sylusing the I.R.I.S. sylusing the I.R.I.S. sylusing the I.R.I.S. sylusing the II.S. sylvastylish the II	et as evidenced by: eview observation and interview implement written policies ponse to incidents as required.  of the facility's "Incident ffective 2/01/98 and revised  II incidents will be reported extem implemented by DHHS." or III incidents: Incidents are ext.I.S. system " ident Manager will notify other ons as deemed appropriate to ess (Department of Social				

Division of Health Service Regulation

STATE FORM BBK611 If continuation sheet 14 of 32

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL096-277	B. WING		07/0	8/2022
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
RENU LI	FE EXTENDED INC		SOR CREEK DRO, NC 27	K PARKWAY 530		
(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 SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
V 366	Services) DHSI Certification Section Personnel Registry - " All incident rethe Q Meeting to didetermine any need to eliminate future i ". " - " Critical Incidemore of the following Alleged Exploitation Review on 6/21/22 Response Improve submitted 4/01/22 or Level III incident facility.  Review on 6/21/22 level II or level III in 4/01/22 - 6/20/22.  Review on 6/21/22 level II or level III in 4/01/22 - 6/20/22.  Review on 6/21/22 - 46 year old male a Diagnoses included Disorder, Depression Disorder, Seizure Emigraines.  During interview on - Former staff #4 (Finelp him get out of - He asked FS#4 to she didn't respond himself in his bed His girlfriend, clier	R Mental Health Licensure & n DHSR Health Care"  eports are reviewed monthly in scuss possible patterns and essary changes in an attempt incidents of a similar nature  ents shall be defined as one or ng: Abuse and neglect, an and/or harassment"  of the North Carolina Incident ment System (IRIS) for reports -6/20/22 revealed no Level II reports submitted by the  of facility records revealed no incident reports completed	V 366			
	body.	vard his head exposing his ient #5] me laying in my poop."				

Division of Health Service Regulation

STATE FORM BBK611 If continuation sheet 15 of 32

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING:			
		MHL096-277	B. WING	<u></u>	07/0	8/2022
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
RENU LI	FE EXTENDED INC		SOR CREEK DRO, NC 27	CPARKWAY 530		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECT	ON	(X5)
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	COMPLETE DATE
V 366	Continued From pa	ge 15	V 366			
	- "I told everybody, told; it was humiliat #6 was observed to about 1/4 inch apar - He remembered t Professional #2 (QI - The incident happ Review on 6/21/22 - 24 year old female - Diagnoses include (TBI), Bipolar I Disc and Polysubstance During interview on - She was client #6 - "[Client #6] had a himself in bed and his room and emba	but I can't remember who I ing; I felt about that big" (client b hold his thumb and forefinger it). elling the Qualified P#2) about the incident. ened "a while ago." of client #5's record revealed: e admitted 7/26/21. ed Traumatic Brain Injury order, Opiate Use Disorder, Use Disorder. 6/22/22 client #5 stated:				
	revealed: - Date of hire 8/02/2 - 2 week notice sub - Date of terminatio - Training dated 8/0 Prevention, Abuse, "Being a Competendated 8/02/21 in "B 7/27/21 in the Licer Abuse, Neglect and During interview on - She was not involute Facility managem what to say.					

Division of Health Service Regulation

STATE FORM BBK611 If continuation sheet 16 of 32

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
,	o. oo		A. BUILDING:			
		MHL096-277	B. WING		07/0	8/2022
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
RENU LI	FE EXTENDED INC		SOR CREEK DRO, NC 27	C PARKWAY 530		
(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 APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
V 366	Continued From pa	ge 16	V 366			
V 367	Coordinator stated: - The incident was - An investigation we particular staff was  During interviews of President of the factor of the factor of the Director of Presuring level II and submitted She did not think a submitted via IRIS.  During interview on Programs stated: - The facility conductor of the allegation of A level III incident IRIS.	reported to her. vas conducted and "that fired." n 6/21/22 and 6/22/22 the	V 367			
V 367	10A NCAC 27G .06 REPORTING REQ CATEGORY A AND (a) Category A and level II incidents, ex the provision of billa consumer is on the incidents and level to whom the provid 90 days prior to the	604 INCIDENT UIREMENTS FOR	V 367			
		ed within 72 hours of the incident. The report shall				

Division of Health Service Regulation

STATE FORM BBK611 If continuation sheet 17 of 32

MHL096-277    B. WING		T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	` ,	E CONSTRUCTION	(X3) DATE	
NAME OF PROVIDER OR SUPPLIER  RENU LIFE EXTENDED INC  201 WINDSOR CREEK PARKWAY GOLDSBORO, NC 27530  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLIANCE OF CORRECTIVE ACTION SHOULD BE COMPLIANCE OF CROSS-REFERENCED TO THE APPROPRIATE DATE	AND PLAN OF	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  201 WINDSOR CREEK PARKWAY GOLDSBORO, NC 27530  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLIANCE OF COMPLIANCE OF COMPLIANCE OF CONSTRUCTION SHOULD BE COMPLIANCE OF COMPLIANCE OF CONSTRUCTION SHOULD BE COMPLIANCE OF CONSTRUCTION SHOULD S			MHL096-277	B. WING		07/0	8/2022
RENU LIFE EXTENDED INC  201 WINDSOR CREEK PARKWAY GOLDSBORO, NC 27530  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  COMPLIANCE TAG CROSS-REFERENCED TO THE APPROPRIATE  DATE	NAME OF PR	ROVIDER OR SUPPLIER	STREET ADI	DRESS CITY S	STATE ZIP CODE	_	
RENU LIFE EXTENDED INC  GOLDSBORO, NC 27530  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  GOLDSBORO, NC 27530  PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE COMPLIANCE CROSS-REFERENCED TO THE APPROPRIATE DATE	TO AME OF THE	NOVIBER OR OUT FIER					
(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 COMPLIATE) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE	RENU LIFE	E EXTENDED INC					
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG CROSS-REFERENCED TO THE APPROPRIATE  COMPLIATORY  TAG CROSS-REFERENCED TO THE APPROPRIATE	()(1) ID	CLIMMA DV CTA				ON	(VE)
	PRÉFIX	(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	LD BE	COMPLETE DATE
V 367 Continued From page 17 V 367	V 367	Continued From pa	ge 17	V 367			
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. (c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including; (1) hospital records including confidential information; (2) reports by other authorities; and (3) the provider's response to the incident. (d) Category A and B providers shall send a copy of all level III incident reports to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of becoming aware of the incident. Category A provider's shall send a copy of all level III	bsinnin(); (i); (i); (i); (i); (i); (i); (i); (	be submitted on a f Secretary. The rep in person, facsimile means. The report information:  (1) reporting identification inform (2) client iden (3) type of ind (4) description (5) status of the cause of the incider (6) other indivor responding.  (b) Category A and missing or incomple shall submit an upd report recipients by day whenever:  (1) the provide erroneous, mislead (2) the provide erroneous, mislead (2) the provide erroneous and upon request by the obtained regarding (1) hospital resinformation;  (2) reports by (3) the provide (4) Category A and (5) of all level III incided (6) Mental Health, Dev Substance Abuse Subecoming aware of	form provided by the port may be submitted via mail, or encrypted electronic shall include the following provider contact and nation; of incident; on of incident; the effort to determine the nt; and viduals or authorities notified. If B providers shall explain any ete information. The provider lated report to all required the end of the next business. Her has reason to believe that d in the report may be ing or otherwise unreliable; or the obtains information dent form that was previously. If B providers shall submit, et LME, other information the incident, including: ecords including confidential of other authorities; and the services within 72 hours of the incident. Category A				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		MHL096-277	B. WING		07/0	8/2022
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	1 0770	OIZUZZ
RENU LI	FE EXTENDED INC		SOR CREEP DRO, NC 27	( PARKWAY 530		
(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 367	becoming aware of client death within sor restraint, the profimmediately, as red0300 and 10A NCA (e) Category A and report quarterly to the catchment area who The report shall be by the Secretary via include summary in (1) medication definition of a level (2) restrictive the definition of a level (3) searches (4) seizures (4) seizures (5) the total mincidents that occur (6) a statement of the critical	ulation within 72 hours of the incident. In cases 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 formation as follows: n errors that do not meet the II or level III incident; interventions that do not meet evel II or level III incident; of a client or his living area; of client property or property in a client; number of level II and level III rred; and ent indicating that there have incidents whenever no urred during the quarter that eria as set forth in Paragraphs (1)	V 367			
	interviews the facilit	views, observation and ty failed to report a critical ours of becoming aware of the				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		MHL096-277	B. WING		07/0	8/2022
	PROVIDER OR SUPPLIER	201 WIND		STATE, ZIP CODE ( PARKWAY 530		
(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 SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
V 367	Continued From pa	ge 19	V 367			
	Response Improver submitted 4/01/22 - or Level III incident facility.  Review on 6/21/22 Internal "Incident 4/08/22 and signed Coordinator (RCC) Incident: told magnet for the coordinator (RCC) Incident:	of the North Carolina Incident ment System (IRIS) for reports 6/20/22 revealed no Level II reports submitted by the  of facility records revealed: Reporting Form" dated by the Resident Care included " "Description of e about a situation involving ner resident and staff. [Client in staff [former staff #4 (FS#4)] ed that he had a bowel ill up. [Client #6] described on as, annoyed. Staff [FS#4] in and returned with another Staff [FS#4] pulled the in of [client #5] and said "Look in versation with [client #5]: Me: in h [FS#4] and [client #6] in his FS#4] asked me to come here she showed me that he in pull up. Me: Are you okay? ened. It should of never ient #6], it didn't bother me."  III incident reports completed in the complete in the completed in the complete in the completed in the complete in the com				

6899

Division of Health Service Regulation STATE FORM

	of Health Service Re		1			
	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		E CONSTRUCTION	(X3) DATE	SURVEY LETED
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LLIEU
		MHL096-277	B. WING		07/0	8/2022
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS CITY S	STATE, ZIP CODE		
TV WIL OI	THOUBER OR GOLF EIER		SOR CREEK			
RENU LI	FE EXTENDED INC		ORO, NC 27			
	OUR MAA DV OTA		1			
(X4) ID PREFIX		TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO		DATE
				DEFICIENCY)		
V 367	Continued From pa	ge 20	V 367			
	During interview on	6/22/22 client #6 stated:				
	- Former staff #4 (F	S#4) came into his room to				
		bed and ready for the day.				
		help him with his bedpan, but				
	-	quickly enough and he soiled				
	himself in his bed.					
		nt #5, was in the hall and FS#4				
		room, pulled the bed sheets				
	up from his feet toward his head exposing his					
	body FS#4 "showed [client #5] me laying in my poop."					
		but I can't remember who I				
		ing; I felt about that big" (client				
		hold his thumb and forefinger				
	about 1/4 inch apar					
	- He remembered to					
		P#2) about the incident.				
	- The incident happ	ened "a while ago."				
	Daview en 6/04/00	of aliant #Fla record revealed.				
		of client #5's record revealed:				
	- 24 year old female	ed Traumatic Brain Injury				
		order, Opiate Use Disorder,				
	and Polysubstance					
	During interview on	6/22/22 client #5 stated:				
	- She was client #6	's girlfriend;				
		bm (bowel movement) on				
		she (FS#4) called me over to				
		rrassed him; it was [FS#4],				
		k here anymore; she got				
	fired."					
	Review on 6/21/22	of FS#4's personnel record				
	revealed:	2 2.// 10 po. 00 mon 1000 m				
		21, title Direct Support Staff.				
	- 2 week notice sub					
	- Date of terminatio	n 4/21/22.				
		5/21 in "Client Rights:				
	Prevention, Abuse,	Neglect & Exploitation";				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING.	<del></del>		
		MHL096-277	B. WING		07/0	8/2022
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
RENU LI	FE EXTENDED INC		SOR CREEK ORO, NC 27			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT	ION	(X5)
PRÉFIX TAG	`	/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)		COMPLETE DATE
V 367	Continued From pa	ge 21	V 367			
	dated 8/02/21 in "B 7/27/21 in the Licer	nt Brain Injury Professional", rain Injury Basics", and dated nsee's "Resident Rights" and If Exploitation policies.				
	- She was not involved: #6.	6/22/22 FS#4 stated: ved in any incident with client ent told client #5 and client #6				
	_	the facility voluntarily.				
	- The incident was	as conducted and "that				
	- He was notified of not report it to any of the internal investig emergency contact - Standard operatin person receiving th	6/27/22 QP#2 stated: if the incident/allegation but did butside agency; his only role in lation was to notify client #6's person of the incident. g procedure was for the e report of an allegation incident report and report the upervisor.				
	President of the factor of the was aware of by client #6.  The Director of Prensuring level II and submitted.	n 6/21/22 and 6/22/22 the cility stated: the allegation of abuse made ograms was responsible for d level III incident reports were a level III incident report was				
	Programs stated:	6/27/22 the Director of cted an internal investigation				

AND DUAN OF CORRECTION \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		MHL096-277	B. WING		07/0	8/2022
NAME OF	PROVIDER OR SUPPLIER		ORESS CITY S	STATE, ZIP CODE	1 0170	OILUL
	FE EXTENDED INC		SOR CREEK	•		
KENU LI	FE EXTENDED INC	GOLDSBO	DRO, NC 27	530		
(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 APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
V 367	Continued From pa	ge 22	V 367			
	- FS#4 gave a 2 we to return to work du employment was te - A level III incident	abuse against FS#4. ek notice but she was told not ring the notice period and her rminated. report was not submitted to s of becoming aware of the				
V 500	27D .0101(a-e) Clie	nt Rights - Policy on Rights	V 500			
	RESTRICTIONS AN  (a) The governing I assures the implem G.S. 122C-65, and  (b) The governing I implement policy to  (1) all instance abuse, neglect or experied to the Couservices as specific G.S. 7A, Article 44;  (2) procedure instituted in accordary practice when a mere present serious risk Particular attention neuroleptic medical (c) In addition to the 10A NCAC 27E .01 each facility shall dethat identifies:  (1) any restrict prohibited from use  (2) in a 24-hounder which staff arthe rights of a client (d) If the governing	body shall develop and assure that:  sees of alleged or suspected exploitation of clients are not pepartment 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. It is shall be given to the use of cions.  Sose procedures prohibited in 102(1), the governing body of evelop and implement policy extive intervention that is within the facility; and our facility, the circumstances are prohibited from restricting				

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		MHL096-277	B. WING		07/0	8/2022
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
RENU LI	FE EXTENDED INC		SOR CREEK			
	OLIMANA DV. OTA		ORO, NC 27		DN .	0.1-1
(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 APPROINT DEFICIENCY)	D BE	(X5) COMPLETE DATE
V 500	Continued From pa	ge 23	V 500			
V 3000	the restrictions of cl 122C-62(b) and (d) identify: (1) the permit allowed restrictions (2) the individent the client; and (3) the due prinvoluntary client where trictive interventia (e) If restrictive interventia (e) If restrictive interventia within the facility, the develop and implend compliance with Su which includes: (1) the design has been trained and competence to use provide written authorize renewed for up to a accordance with the NCAC 27E .0104(e) (2) the design responsible for revisite reventions; and (3) the establication appeal for the resolution over the planned use the saled on record resinterviews the facility of resident abuse by	ient rights specified in G.S. are allowed, the policy shall ted restrictive interventions or flual responsible for informing rocess procedures for an ano refuses the use of ons.  erventions are allowed for use the governing body shall then policy that assures the behapter 27E, Section .0100, and who has demonstrated restrictive interventions, to orization for the use of ons when the original order is total of 24 hours in the time limits specified in 10A ()(10)(E); that in the use of restrictive intervention of an individual to be the use of the use of restrictive ishment of a process for ution of any disagreement are of a restrictive intervention.	V 300			

6899

Division of Health Service Regulation STATE FORM

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED
		MHL096-277	B. WING		07/	08/2022
RENULIEE EXTENDED INC 201 WINI			DRESS, CITY, S SOR CREEK DRO, NC 27!			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
V 500	Review on 6/21/22 - Review on 6/21/22 revealed: - 46 year old male a - Diagnoses included Disorder, Depression Disorder, Seizure Disorder,	of client #6's record revealed: 2 of client #6's record admitted 2/06/07. ad TBI, Major Neurocognitive on, Unspecified Mood (Affect) bisorder, and Chronic  6/22/22 client #6 stated: (S#4) came into his room to bed and ready for the day. The help him with his bedpan, but quickly enough and he soiled at #5, was in the hall and FS#4 room, pulled the bed sheets ward his head exposing his ent #5] me laying in my poop." but I can't remember who I ing; I felt about that big" (client to hold his thumb and forefinger t). telling thee Qualified P#2) about the incident. ened "a while ago."  of client #5's record revealed: admitted 7/26/21. ad Traumatic Brain Injury order, Opiate Use Disorder, Use Disorder.  6/22/22 client #5 stated:	V 500			

Division of Health Service Regulation

STATE FORM BBK611 If continuation sheet 25 of 32

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		· ,	. ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		MHL096-277	B. WING		07/0	8/2022
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
RENU LI	FE EXTENDED INC		SOR CREEK			
0(0)15	CLIMMA DV CTA		ORO, NC 27		ON	()(5)
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC 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 500	Continued From pa	ge 25	V 500			
	fired."					
	revealed: - Date of hire 8/02/2 - 2 week notice sub - Date of terminatio - Training dated 8/0 Prevention, Abuse, "Being a Competendated 8/02/21 in "B 7/27/21 in the Licer Abuse, Neglect and During interview on - She was not involved Facility management what to say She left her job at Review on 6/21/22 revealed no docum an allegation of abu	n 4/21/22. 15/21 in "Client Rights: Neglect & Exploitation"; It Brain Injury Professional", rain Injury Basics", and dated asee's "Resident Rights" and I Exploitation policies. 6/22/22 FS#4 stated: ved in any incident with client ent told client #5 and client #6 the facility voluntarily. and 6/22/22 of facility records entation the facility reported				
	it to any agency; his investigation was to	ent/allegation but did not report s only role in the internal o notify client #6's emergency ne incident.				
	contact person of the incident.  During interviews on 6/21/22 and 6/22/22 the President of the facility stated: - She was aware of the allegation of abuse made by client #6 The Director of Programs was responsible for notifying DSS of allegations of abuse She did not think DSS was notified of the allegation of abuse.					

6899

Division of Health Service Regulation STATE FORM

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA  IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		MHL096-277	B. WING		07/0	8/2022
NAME OF I			DDEOG OITY (	OTATE ZID CODE	1 0770	OIZUZZ
	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE <b>( PARKWAY</b>		
RENU LI	FE EXTENDED INC		DRO, NC 27			
(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 SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
V 500	Continued From pa	ge 26	V 500			
	Programs stated: - The facility conduction of the allegation of a FS#4 gave her 2 v - She told FS#4 not week notice.	6/27/22 the Director of cted an internal investigation abuse against FS#4. week notice. to return to work during the 2 fied of the allegation of abuse.				
V 540	Grooming  10A NCAC 27F .010 AND GROOMING (a) Each client shadignity, privacy and of personal health, Such rights shall into the: (1) opportunit daily, or more often (2) opportunit (3) opportunit barber or a beautici (4) provision paper and soap for individual personal indigent client. Such not limited to toothp napkins, tampons, sutensil. (b) Bathtubs or shoindividual privacy shoildividual pri	Il be assured the right to humane care in the provision hygiene and grooming care. clude, but need not be limited by for a shower or tub bath as needed; by to shave at least daily; by to obtain the services of a an; and of linens and towels, toilet each client and other hygiene articles for each in other articles include but are easte, toothbrush, sanitary shaving cream and shaving owers and toilets which ensure hall be available.	V 540			

6899

Division of Health Service Regulation STATE FORM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					SURVEY LETED	
	MHL096-277		B. WING		07/0	8/2022
RENULLIFE EXTENDED INC 201 WIND			ORESS, CITY, S SOR CREEK DRO, NC 27			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES '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)	ILD BE	(X5) COMPLETE DATE
V 540	This Rule is not me Based on record reinterviews the facilit right to dignity, privary provision of personal grooming care for 1 findings are:  Review on 6/21/22 - 46 year old male a - Diagnoses included (TBI), Major Neurod Depression, Unspe Seizure Disorder, a  During interview and approximately 12:18 stated: - Former staff #4 (Finding him get out of the He asked FS#4 to she didn't respond of himself in his bed His girlfriend, clier brought her into his up from his feet tow body FS#4 "showed [cliter of the him get out of the him get out of the him get out of the himself in his bed His girlfriend, clier brought her into his up from his feet tow body FS#4 "showed [cliter of the himself of th	et as evidenced by: views, observation and by failed to ensure a client's acy and humane care in the al health, hygiene and of 3 audited clients (#6). The of client #6's record revealed: admitted 2/06/07. ed Traumatic Brain Injury cognitive Disorder, cified Mood (Affect) Disorder, nd Chronic Migraines. d observation at 5 pm on 6/22/22 client #6 (S#4) came into his room to bed and ready for the day. Thelp him with his bedpan, but quickly enough and he soiled at #5, was in the hall and FS#4 room, pulled the bed sheets ward his head exposing his but I can't remember who I and I felt about that big." erved to hold his thumb and inch apart. elling the Qualified D#2) about the incident.	V 540			

Division of Health Service Regulation

STATE FORM BBK611 If continuation sheet 28 of 32

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA			(X3) DATE COMP	SURVEY LETED
		MHL096-277	B. WING		07/0	8/2022
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
RENU LI	FE EXTENDED INC		SOR CREEK			
()(1) ID	STIMMA DV STA	TEMENT OF DEFICIENCIES	ORO, NC 27	PROVIDER'S PLAN OF CORRECT	ION	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRODEFICIENCY)	LD BE	(X5) COMPLETE DATE
V 540	Continued From pa	ge 28	V 540			
	Review on 6/21/22 of client #5's record revealed: - 24 year old female admitted 7/26/21 Diagnoses included TBI, Bipolar I Disorder, Opiate Use Disorder, and Polysubstance Use Disorder.  During interview on 6/22/22 client #5 stated: - She was client #6's girlfriend "[Client #6] had a bm (bowel movement) on himself in bed and she (FS#4) called me over to his room and embarrassed him; it was [FS#4], but she doesn't work here anymore; she got fired."  Review on 6/21/22 of FS#4's personnel record revealed: - Date of hire 8/02/21, title Direct Support Staff 2 week notice submitted 4/10/22 Date of termination 4/21/22 Training dated 8/05/21 in "Client Rights: Prevention, Abuse, Neglect & Exploitation"; "Being a Competent Brain Injury Professional", dated 8/02/21 in "Brain Injury Basics", and dated 7/27/21 in the Licensee's "Resident Rights" and Abuse, Neglect and Exploitation policies.					
	- She was not involved: #6. - Facility management what to say.	6/22/22 FS#4 stated: ved in any incident with client ent told client #5 and client #6 the facility voluntarily.				
	Coordinator stated: - The incident was i - An investigation w particular staff (FS#	reported to her. ras conducted and "that				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		MHL096-277	B. WING		07/0	08/2022
NAME OF I	PROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, S	STATE, ZIP CODE		
RENU LI	FE EXTENDED INC		SOR CREEK DRO, NC 27	C PARKWAY 530		
(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 APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
V 540	notified of the incide it to any agency; his investigation was to contact person of the During interview on Programs stated:  - The facility conduct of the allegation age - FS#4 gave her 2 verturn to work during During interviews of the President of the - She was aware of by client #6.  - "This happened."  - When interviewed investigation, forme incident occurred at that abuse could be - This was "the first by a staff member of the review on 6/27/22 and signed revealed:  - "What immediate ensure the safety of Staff will continue to training with an empsupervisor will make are no violations of This will be done by conversations with - Describe your plan happens. 'Spot che	ent/allegation but did not report is only role in the internal in notify client #6's emergency he incident.  6/27/22 the Director of oted an internal investigation abuse against FS#4. A sinst FS#4 was substantiated. Week notice but was told not to g the 2 week notice period.  In 6/21/22, 6/22/22 and 6/27/22 and 6/27/22 and a facility stated: the allegation of abuse made for the facility's internal ar staff #4 did not deny the and did not seem to understand a facility and of resident abuse or us in 23 years."  In 6/21/25 the Director of Programs action will the facility take to for the consumers in your care?	V 540			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '			SURVEY LETED	
		MHL096-277	B. WING		07/0	8/2022
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
DENILLI	EE EVTENDED INC	201 WIND	SOR CREEK	( PARKWAY		
KENU LI	FE EXTENDED INC	GOLDSBO	DRO, NC 27	530		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	D BE	(X5) COMPLETE DATE
V 540	Continued From pa	ge 30	V 540			
	Supervisor will hold a meeting with staff from all shifts on 6/27/22 into 6/28/22 to discuss the importance of resident rights and dignity."					
	Client #6 had diagn Injury, Major Neuro Depression, Unspe Seizure Disorder, a required assistance personal care tasks personal hygiene. Direct Care Staff in new employee orien prevention of abuse the facility's abuse, policies. On the mo #4 assisted client # Client #6 reported whedpan, former staff enough and he soill Former staff #4 the #6's room and pulle #6's head exposing #5 that he had soill reported feeling hur During interview for involvement in the incorroborated the rean internal investigation of abuse against for substantiated and from the facility was the abuse incident. The client #6's right to do care in the provision grooming care consider serious abuse and for serious an	oses of Traumatic Brain cognitive Disorder, cified Mood (Affect) Disorder, cified Mood (Affect) Disorder, and Chronic Migraines. He with completion of basic such as toileting and Former staff #4 was hired as a August 2021. She completed attation training in client rights, and exploitation and neglect and exploitation rning of 4/08/22 former staff 6 with his morning routine. When he asked her for a ff #4 did not respond quickly and himself and his bed. In called client #5 into client and the sheets up over client his body and showing client and himself in his bed. Client #6 miliated by former staff #4. In the sheets up over client and himself in his bed. Client #6 miliated by former staff #4. In the sheet was promer staff #4 was pormer s				
	policies. On the mo #4 assisted client #6 reported we bedpan, former star enough and he soils Former staff #4 the #6's room and pulle #6's head exposing #5 that he had soils reported feeling hur During interview for involvement in the it corroborated the rean internal investigated for abuse against for substantiated and frat the facility was teabuse incident. The client #6's right to decare in the provision grooming care consifer serious abuse a 23 days. An adminimposed. If the viole	rning of 4/08/22 former staff 6 with his morning routine. When he asked her for a ff #4 did not respond quickly ed himself and his bed. In called client #5 into client ed the sheets up over client his body and showing client ed himself in his bed. Client #6 miliated by former staff #4. Immer staff #4 denied incident but client #5 port. The facility conducted eation and client #6's allegation ormer staff #4 was ormer staff #4 was ormer staff #4's employment eminated as a result of the efacility's failure to ensure ignity, privacy and humane in of personal hygiene and estitutes a Type A1 rule violation				

Division of Health Service Regulation

STATE FORM BBK611 If continuation sheet 31 of 32

MHL096-277  B. WING	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  201 WINDSOR CREEK PARKWAY  GOLDSBORO, NC 27530   (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  V 540 Continued From page 31  V 540 S500.00 per day will be imposed for each day the			A. BUILDING:	:		
RENU LIFE EXTENDED INC  201 WINDSOR CREEK PARKWAY GOLDSBORO, NC 27530  (X4) ID PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  V 540  Continued From page 31  \$500.00 per day will be imposed for each day the		MHL096-277	B. WING		07/0	8/2022
(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  V 540 Continued From page 31  \$500.00 per day will be imposed for each day the	NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  V 540  Continued From page 31  \$500.00 per day will be imposed for each day the	RENU LIFE EXTENDED INC					
\$500.00 per day will be imposed for each day the	PREFIX (EACH DEFICIENCY I	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	D BE	(X5) COMPLETE DATE
	\$500.00 per day will	be imposed for each day the	V 540	DELIGITION ()		

6899

Division of Health Service Regulation
STATE FORM