

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL043059</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>07/21/2022</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>PROFESSIONAL FAMILY CARE HOME #5</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>19 SUSIE CIRCLE</b> <b>CAMERON, NC 28326</b>
---	---

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 000	<p><b>INITIAL COMMENTS</b></p> <p>An annual, complaint and follow up survey was completed on 07/21/22. The complaints were substantiated (#NC00190473 &amp; #NC00190231). Deficiencies were cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disability.</p> <p>This facility is licensed for 3 and currently has a census of 2. The survey sample consisted of audits of 2 current clients.</p>	V 000		
V 114	<p><b>27G .0207 Emergency Plans and Supplies</b></p> <p>10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES</p> <p>(a) A written fire plan for each facility and area-wide disaster plan shall be developed and shall be approved by the appropriate local authority.</p> <p>(b) The plan shall be made available to all staff and evacuation procedures and routes shall be posted in the facility.</p> <p>(c) Fire and disaster drills in a 24-hour facility shall be held at least quarterly and shall be repeated for each shift. Drills shall be conducted under conditions that simulate fire emergencies.</p> <p>(d) Each facility shall have basic first aid supplies accessible for use.</p> <p>This Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure disaster drills were completed quarterly and on each shift. The findings are:</p>	V 114		

Division of Health Service Regulation LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
--	-------	-----------

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL043059</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>07/21/2022</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>PROFESSIONAL FAMILY CARE HOME #5</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>19 SUSIE CIRCLE</b> <b>CAMERON, NC 28326</b>
---	---

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 114	Continued From page 1  Review on 6/25/22 of the facility's fire/disaster drill book revealed: - No disaster drills documented since 11/2021-6/2022  Interview on 6/25/22 the Qualified Professional stated: - There had been some confusion with how many drills to complete. - The home schedule included first, second and third shifts - He will monitor drills documentation	V 114		
V 512	27D .0304 Client Rights - Harm, Abuse, Neglect  10A NCAC 27D .0304 PROTECTION FROM HARM, ABUSE, NEGLECT OR EXPLOITATION (a) Employees shall protect clients from harm, abuse, neglect and exploitation in accordance with G.S. 122C-66. (b) Employees shall not subject a client to any sort of abuse or neglect, as defined in 10A NCAC 27C .0102 of this Chapter. (c) Goods or services shall not be sold to or purchased from a client except through established governing body policy. (d) Employees shall use only that degree of force necessary to repel or secure a violent and aggressive client and which is permitted by governing body policy. The degree of force that is necessary depends upon the individual characteristics of the client (such as age, size and physical and mental health) and the degree of aggressiveness displayed by the client. Use of intervention procedures shall be compliance with Subchapter 10A NCAC 27E of this Chapter. (e) Any violation by an employee of Paragraphs (a) through (d) of this Rule shall be grounds for dismissal of the employee.	V 512		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL043059</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>07/21/2022</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>PROFESSIONAL FAMILY CARE HOME #5</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>19 SUSIE CIRCLE</b> <b>CAMERON, NC 28326</b>
---	---

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 512	<p>Continued From page 2</p> <p>This Rule is not met as evidenced by: Based on interview, observation and record review 1 of 4 staff (House Manager/Transportation Staff) neglected 1 of 2 audited clients (#2). The findings are:</p> <p>Review on 6/24/22 of Client #2's record revealed:</p> <ul style="list-style-type: none"> <li>- Admitted: 11/14/19</li> <li>- Age: 39</li> <li>- Diagnoses: Major Neurocognitive Disorder due to Traumatic Brain Injury (with behavioral disturbance), Mild Intellectual Disability, Unspecified Depressive Disorder with anxious Distress, Osteoporosis and Seizure Disorder</li> <li>- Treatment Plan dated 11/1/21 "...She has to be monitored at all times for she will walk off and be inappropriate with the other sex...[Client #2] doesn't know her boundaries at the time and is inappropriate with the opposite sex. She is promiscuous with males that had potential for harmful consequences... Constant monitoring when in the community due to inappropriateness with the opposite sex."</li> </ul> <p>Review on 6/27/22 of the House Manager/Transportation Staff's personnel record revealed:</p> <ul style="list-style-type: none"> <li>- Hired: 3/14/17</li> <li>- Training: Core competencies, Client rights, treatment plans</li> </ul> <p>Review on 7/14/22 of the video of the Forensic Interview conducted at the police department on 6/24/22 of Client #2 revealed:</p> <ul style="list-style-type: none"> <li>- She stated she lived in a group home</li> <li>- She wanted to talk about getting raped</li> <li>- The person (House Manager/Transportation</li> </ul>	V 512		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL043059</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>07/21/2022</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>PROFESSIONAL FAMILY CARE HOME #5</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>19 SUSIE CIRCLE</b> <b>CAMERON, NC 28326</b>
---	---

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
--------------------	--	---------------	---	--------------------

V 512	<p>Continued From page 3</p> <p>Staff) that drops her off at the house raped her</p> <ul style="list-style-type: none"> <li>- House Manager/Transportation Staff checked the rooms, checked housemate room first</li> <li>- "Came to check my room and closed the door when he came in my room, which should not have been done.</li> <li>- Pulled his pants down half way and his underwear down too, pretty much told me to do the same thing"</li> <li>- "He left white stuff on the floor from you know"</li> <li>- Came over to the bed "he pulled down my pants and underwear down, told me to get on the bed, and pulled my legs down to him"</li> <li>- "I was scared couldn't scream"</li> <li>- "He put his penis in my v-jayjay"</li> <li>- Had to clean off the bed with 2 paper towels, and had to wash blankets cause blood was on it</li> <li>- The blood came "from me."</li> <li>- "I had to rush to the bathroom cause I had to pee</li> <li>- Drips of blood on the floor and on the toilet"</li> <li>- "Told [staff #1] what happened to me"</li> <li>- Had to "put panty liners on because I don't have any pads cause I was bleeding"</li> <li>- "He (House Manager/Transportation Staff) had a blood spot on his shirt"</li> <li>- Housemate (client#1) outside smoking and was watching the other 2 clients from the other group home</li> <li>- "Hasn't worked with us anymore"</li> <li>- "Told the sheriff, [staff #1 and the Qualified Professional (QP)]" about being raped</li> </ul> <p>Interview on 7/6/22 Client #1 stated:</p> <ul style="list-style-type: none"> <li>- The incident that happened with client #2 happened on the day that staff #2 was late for work and "a pay date" (6/10/22)</li> <li>- The House Manager/Transportation Staff had to meet staff #2 at the local convenience store</li> </ul>	V 512		
-------	---	-------	--	--

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL043059</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>07/21/2022</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>PROFESSIONAL FAMILY CARE HOME #5</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>19 SUSIE CIRCLE</b> <b>CAMERON, NC 28326</b>
---	---

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 512	<p>Continued From page 4</p> <p>and "we got in the car with [staff #2]"</p> <ul style="list-style-type: none"> <li>- She "didn't hear anything"</li> <li>- The House Manager/Transportation Staff told "me to go outside and keep an eye on the client from another home since he would walk away sometime"</li> <li>- The House Manager/Transportation Staff had gone into client #2's room and closed the door</li> <li>- Doesn't know how long the House Manager/Transportation Staff was in client #2's room</li> <li>- When the House Manager/Transportation Staff came out of client #2's room "he had spot of blood on his shirt"</li> <li>- Asked client #2 "was she ok?"</li> <li>- She was with client #2 when she purchased a pregnancy test at the store</li> <li>- She told staff #1 that client #2 had purchased a pregnancy test.</li> </ul> <p>Interview on 6/29/22 Staff #1 stated:</p> <ul style="list-style-type: none"> <li>- Client #1 reported to her that client #2 had purchased a pregnancy test when they were at the store on Friday (date unknown)</li> <li>- She asked client #2 "why would you buy a pregnancy test?"</li> <li>- Client #2 told her she needed to make sure she wasn't pregnant</li> <li>- She told client #2 "you have to have sex to be pregnant" and client #2 "just looked at me"</li> <li>- She then walked client #2 into her bedroom and asked her "what was going on"</li> <li>- Client #2 told her every time (home manager/transportation staff) brings her home she has sex with him</li> <li>- Client #2 was upset when she talked about what had happened</li> <li>- She reported what client #2 told her to her co-worker and they called the Qualified Professional (QP).</li> </ul>	V 512		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL043059</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>07/21/2022</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>PROFESSIONAL FAMILY CARE HOME #5</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>19 SUSIE CIRCLE</b> <b>CAMERON, NC 28326</b>
---	---

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 512	<p>Continued From page 5</p> <ul style="list-style-type: none"> <li>- The QP came to the home and interviewed everyone in the home.</li> <li>- It was a Sunday afternoon client #2 was taken to the doctor on Monday morning.(5/16/22)</li> <li>- Unsure of what happened after that</li> <li>- She had not seen the Home manager/transportation staff transport the female clients since that day.</li> </ul> <p>Interview on 6/29/22 &amp; 7/7/22 Staff #2 stated:</p> <ul style="list-style-type: none"> <li>- He was not aware of what client #2 had purchased at the store, was told later by staff #1 a pregnancy test was purchased</li> <li>- He was informed by staff #1 of the allegation</li> <li>- He asked client #2 did she know what she was saying and asked her to describe it</li> <li>- Client #2 described sex and said it happened more than once.</li> <li>- He called the QP to report what he and his co-worker were told.</li> <li>- He called the House Manager/Transportation Staff earlier that day and asked him to come to the house.</li> <li>- He called him again and told him not to come to the house until he hears from the QP</li> <li>- When the QP arrived he was interviewed</li> <li>- He didn't remember or hadn't noticed any spot on any clothing when he met the House Manager/Transportation Staff at the local convenience store.</li> <li>- Client #1 and client #2 "seemed to be normal"</li> <li>- He had previously spoken to the House Manager/Transportation Staff about client #2 "crushing on him, told him to be careful around her"</li> <li>- He would not be alone with her and would always have another client or staff with him when he worked at the group home.</li> </ul> <p>Interview on 6/27/22 the QP stated:</p>	V 512		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL043059</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>07/21/2022</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>PROFESSIONAL FAMILY CARE HOME #5</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>19 SUSIE CIRCLE</b> <b>CAMERON, NC 28326</b>
---	---

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 512	<p>Continued From page 6</p> <ul style="list-style-type: none"> <li>- He was made aware of the allegation on 5/15/22 at 3:00pm</li> <li>- He went to the group home to complete an incident report, called the Licensee, called the local police, called the guardian and started the investigation.</li> <li>- He, along with a female staff, took client #2 to the doctor's office the next day, Monday morning, 5/16/22.</li> <li>- The doctor's office sent them to the hospital to have a rape kit completed.</li> <li>- He met with the Licensee and they agreed to remove all males from the schedule at the female group home.</li> <li>- He informed the House Manager/Transportation Staff he was no longer needed to pick up the clients for that home.</li> <li>- Client #2's guardian removed her from the home on 6/23/22 and she hadn't returned her to the home.</li> <li>- Client #2 had not been discharged from the group home</li> <li>- He had given House Manager/Transportation Staff a "verbal supervision that included not being alone with client #2, not allowing her to ride in the front seat in the van while transporting and not putting yourself in a compromising position."</li> <li>- Didn't remember the date of the supervision, but it was around February or March of 2022</li> </ul> <p>Interview on 7/13/22 the day program staff stated:</p> <ul style="list-style-type: none"> <li>- She previously advised House Manager/Transportation Staff to be "careful" around client #2</li> <li>- She talked with the House Manager/Transportation Staff about "the male client moving to the back seat allowing [client #2] to sit in the front seat."</li> <li>- She told the House Manager/Transportation Staff months ago that "things don't look right</li> </ul>	V 512		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL043059</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>07/21/2022</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>PROFESSIONAL FAMILY CARE HOME #5</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>19 SUSIE CIRCLE</b> <b>CAMERON, NC 28326</b>
---	---

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 512	<p>Continued From page 7</p> <p>when you're with [client #2]"</p> <p>Interview on 7/12/22 the House Manager/Transportation Staff stated:</p> <ul style="list-style-type: none"> <li>- He was the House manager but had not worked with the clients at this home.</li> <li>- He transported the clients from the day program and took clients to doctor's appointments</li> <li>- He had received training on all client's treatment plans</li> <li>- One of the duties when he transported the clients to the home, he would go in the home to check their bedrooms</li> <li>- He was told by staff #2 that client #2 had "a little crush or like him, be careful around her "</li> <li>- Day program staff told him "I believe she has a crush on you"</li> <li>- He called his QP and told him what the day program staff said and told him "I don't want to get in any trouble around that girl" (client#2)</li> <li>- He received a verbal supervision about where client #2 should sit when on the van ride and not to be alone with client #2 from his QP</li> <li>- He didn't remember the date of the supervision only that it was earlier this year</li> <li>- He was told by the QP not to put himself in a compromising position with client #2 or any client</li> <li>- On 6/10/22 he received a phone call from staff #2 to let him know he was going to be late, didn't know what time staff #2 called to inform him</li> <li>- On 6/10/22 "I did go in her room and she [client #2] closed the bedroom door."</li> <li>- Was in the room "maybe a couple of seconds"</li> <li>- Client #1 "wanted to talk about her house mate. She does that sometimes and she wanted me to hold the hermit crab she had just purchased "</li> <li>- Client #1 closed the door, "I wasn't thinking"</li> </ul>	V 512		



Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL043059</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>07/21/2022</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>PROFESSIONAL FAMILY CARE HOME #5</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>19 SUSIE CIRCLE</b> <b>CAMERON, NC 28326</b>
---	---

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 512	<p>Continued From page 8</p> <ul style="list-style-type: none"> <li>- He didn't remember telling client #1 to go outside to watch the other client</li> <li>- "I may have said it cause the client from the other home will walk off sometime"</li> <li>- "I did not have sex with her"(client #2)</li> <li>- There wasn't a stain on his shirt when he came out of client #2's room</li> </ul> <p>Observation on 6/27/22 at 1:00pm of the group home surveillance tape:</p> <ul style="list-style-type: none"> <li>- 15:06 (3:06pm): Clients and House Manager/Transportation Staff arrived at the home on 5/16/22</li> <li>- 15:19 (3:19pm): Client #2 entered her bedroom</li> <li>- 15:20 (3:20pm): Staff #4 arrived at the group home</li> <li>- 15:20:04 (3:20pm): The House Manager/Transportation Staff entered client #2's bedroom and closed the door</li> <li>- 15:21:11 (3:21pm): The House Manager/Transportation Staff exited client #2's bedroom</li> <li>- 15:22:03 (3:22pm): The House Manager/Transportation Staff entered client #2's bedroom</li> <li>- 15:23:42 (3:23pm): The House Manager/Transportation Staff closed client #2's bedroom door</li> <li>- 15:24:01 (3:24pm): The House Manager/Transportation Staff exited client #2's bedroom</li> <li>- 15:27:18 (3:27pm): The House Manager/Transportation Staff entered client #2's bedroom and closed the door</li> <li>- 15:28:39 (3:28pm): The House Manager/Transportation Staff exited client #2's bedroom</li> <li>- 15:29 (3:29pm): The House Manager/Transportation Staff walked back in</li> </ul>	V 512		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL043059</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>07/21/2022</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>PROFESSIONAL FAMILY CARE HOME #5</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>19 SUSIE CIRCLE</b> <b>CAMERON, NC 28326</b>
---	---

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 512	<p>Continued From page 9</p> <p>client #2's bedroom and closed the door</p> <ul style="list-style-type: none"> <li>- 15:33 (3:33pm): The House Manager/Transportation Staff exited client #2's bedroom</li> </ul> <p>Observation on 7/7/22 at 10:30am of the group home surveillance tape:</p> <ul style="list-style-type: none"> <li>- 15:44:43 (3:44pm): Clients and staff arrived at the home on 6/10/22</li> <li>- 15:45:46 (3:45pm): The House Manager/Transportation Staff walked in client #2's bedroom</li> <li>- 15:45:46 (3:45pm): Client #2 walked in her room and closed her door</li> <li>- 15:46:01 (3:46pm): The House Manager/Transportation Staff exited client #2's bedroom and there was no spot on his shirt</li> <li>- 15:49 (3:49pm): The House Manager/Transportation Staff said something to client #1 and she went out the front door</li> <li>- 15:50:10 (3:50pm): The House Manager/Transportation Staff went into client #2's bedroom and the door closed at 15:50:11 (3:50pm)</li> <li>- 15:54:15 (3:54pm): The House Manager/Transportation Staff opened the door and came out of client #2's bedroom</li> <li>- There was a spot the size of a quarter on the House Manager/Transportation Staff shirt under his belly button toward the bottom of his shirt when he came out of the room</li> <li>- 16:06 (4:06pm): Client #2 came out of her bedroom with two full grocery store bags and walked out the front door</li> <li>- 16:07 (4:07pm): The House Manager/Transportation Staff came back in the home and walked in the direction of the bathroom</li> <li>- 16:08 (4:08pm): The House Manager/Transportation Staff walked out of the house</li> </ul>	V 512		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL043059</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>07/21/2022</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>PROFESSIONAL FAMILY CARE HOME #5</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>19 SUSIE CIRCLE</b> <b>CAMERON, NC 28326</b>
---	---

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 512	<p>Continued From page 10</p> <p>- 16:17:29 (4:17pm): Everyone left the house</p> <p>Review on 7/12/22 of facility's Plan of Protection dated 7/12/22 submitted and written by QP/Residential Director revealed: " What immediate action will the facility take to ensure the safety of the consumers in your care? All males were immediately taken off shift at the Susie Circle facility. No males will be on shift at the facility as long as it is a female home. No male staff will transport a female client without a female being present. Describe you plans to make sure the above happens. All staff will continue receiving monthly supervision including reviewing the clients service plans. Any incident reported will include an incident report being completed, and if needed an investigation will be conducted.</p> <p>Client #2 had diagnoses of Major Neurocognitive Disorder due to Traumatic Brain Injury, Mild Intellectual Disability, Unspecified Depressive Disorder with anxious Distress, Osteoporosis, Seizure Disorder. Client #2 needed supports with promiscuity and inappropriate boundaries with the opposite sex. Although, the House Manager/ Transportation Staff neglected to follow the precautions that put himself in a compromising position with client #2, where she made an allegation of rape. The QP had given the House Manager/Transportation Staff verbal supervision which included him not being alone with client #2 and not putting himself in a compromising position with her. The day program staff had advised the House Manager/Transportation Staff to be careful around client #2. However, despite the verbal and written plans in place the House Manager/Transportation Staff continued to go in client #2's bedroom and closed the door</p>	V 512		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL043059</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>07/21/2022</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>PROFESSIONAL FAMILY CARE HOME #5</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>19 SUSIE CIRCLE</b> <b>CAMERON, NC 28326</b>
---	---

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 512	Continued From page 11  numerous times on 5/16/22 and 6/10/22. This constitutes a Type A1 rule violation for serious neglect and must be corrected within 23 days. An administrative penalty of \$1000.00 is imposed. If the violation is not corrected within 23 days, an additional administrative penalty of \$500.00 per day will be imposed for each day the facility is out of compliance beyond the 23rd day.	V 512		