STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION G:		(X3) DATE SURVEY COMPLETED		
		MHL040-019	B. WING		08/	08/08/2022	
NAME OF	PROVIDER OR SUPPLIER		EET ADDRESS, CITY,				
EASTER	SEALS UCP-GREEN	F COUNTY GROL	SE SECOND STE W HILL, NC 285				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE	
V 000	INITIAL COMMENT	TS .	V 000				
	2022. One complain #NC00191306) and unsubstantiated (into Deficiencies were controlled to This facility is licens category: 10A NCA Living for Adults with This facility is license.	sed for the following service C 27G .5600C Supervised h Developmental Disabilitied for 6 and currently has survey sample consisted of	ce d des.				
V 132	G.S. 131E-256(G) I 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.	EALTH CARE PERSONNE lities shall ensure that the led of all allegations again hel, including injuries of hich appear to be related adivision (a)(1) of this sect are of a resident in a health to whom home care service 131E-136 or hospice service 131E-201 are being provice of the property of a residulty, as defined in subsect accluding places where home fined by G.S. 131E-136 or defined by G.S. 131E-20 and the property of a legs belonging to a health of the or client.	st to ion. care ses ices ded. dent ion ne r				

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

TITLE (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		MHL040-019	B. WING		08/	08/2022
	PROVIDER OR SUPPLIER	F COUNTY GROL 704 SE S	DDRESS, CITY, ST SECOND STRE ILL, NC 28580	ET		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
V 132	e. Fraud against a a patient or client for providing services). Facilities must have acts are investigate to protect residents investigation is in provestigations must	a health care facility or against or whom the employee is . The evidence that all alleged ed and must make every effort of from harm while the rogress. The results of all to be reported to the five working days of the initial	V 132			
	facility failed to report the Health Care Perfindings are: Review on 08/04/22 Response Improve revealed: - No level II incident facility for client #6's staff on 07/13/22. - An IRIS report gets support agency register.	eviews and interviews the cort an allegation of abuse to be a second Registry (HCPR). The area of the North Carolina Incident ment System (IRIS) website to the second Registry (HCPR) and the second Registry (IRIS) website to the second Registry (IRIS) website	t			

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STATE FORM 6899 QEK811 If continuation sheet 2 of 14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		MHL040-019		B. WING		08/	08/2022
	PROVIDER OR SUPPLIER	E COUNTY GROL	704 SE SE	DRESS, CITY, S ECOND STRI LL, NC 2858			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORM	/ FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
V 132	Review on 08/04/22 Behavior Support P - "Target Behavior I Making false report health and safety or perpetrated by staff seizure." - Recommendation BehaviorsIf [Clien you a story suggest or neglected her, yo definitively want to be something bad is he been a lot of times that aren't true and you sure what what she insists the story will follow up with tr administrative staff, well. Document any and follow up with tr recants or not. Follo procedures regardin substantiated claim Review on 08/04/22 investigation dated - "RE (regarding): F - Client #6 had a gu Department of Soci - Client #6 had resi years and received - Client #6 had a di - "Overview Discuss director (Qualified F aware that [Client # gone into her room room up. She state	2 of client #6's Individent dated 09/13/21 DefinitionsFabricates of maltreatment, reference of the or others report. Pretending to have as & Intervention/Reset #6] speaks to you ting that someone has bushould say, '[Client be able to help you it appening to you, the that you have told makes it harder to he you're telling me is you're tellin	revealed: tions: isks to tedly e a sponse to and tells as harmed nt #6], I f ere have ne things nelp. Are true?'. If w that you nome now as neglect er she and g for gation." cal ntative. me for 3 up Home ecame staff had are her 3:00am.	V 132			

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STATE FORM 6899 QEK811 If continuation sheet 3 of 14

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		MHL040-019	B. WING		08/0	08/08/2022	
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	-		
FASTER	SEALS UCP-GREEN	F COUNTY GROU 704 SE SE	COND STR	EET			
LAGILIN	SLALS OUF-GILLIN	SNOW HII	LL, NC 2858	80			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	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 132	7:30am. The mana 3:00am completing	ger was at the home at fire drills with staff. They did	V 132				
	not wake [Client #6] at the time. This was a training for staff on how to complete drills in the middle of the night This is on the Fire Drill Document. The individual's room was cleaned -						
	manager asked how cleaned - she said	w did they trash it if the room is they must have cleaned it					
	back up. The Manager told [Client #6] she was at the home at 3:00am conducting the fire drill. [Client #6 said this must have happened on another day. 2 staff on shift, both staff were						
	questioned - both s notified the guardia	aid this did not occur. Staff n that day. The guardian's					
	an ongoing issue w documented in her	e we go again' - This has been ith [Client #6]. This is plan and her BSP (Behavior allegation was retracted the					
	same day." - "According to the	incident report Manual and as an occurrence that is not					
	typical for the indivi could lead to adver	dual and service delivered an se effects to the individual. this or the individual as identified in					
	the individual's plar - "Conclusion: Unsu	and her BSP."					
		al Services was notified of the					
	Interview on 08/04/22 and 08/08/22 the Regional Director stated: - Client #6 had a history of making false allegations of abuse against staff Client #6 had a behavior support plan to						
	#6 retracted her all	dent was short because client egation.					
	 She understood a reported to the HCF 	Il allegations of abuse must be PR.					

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STATE FORM 6899 QEK811 If continuation sheet 4 of 14

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		MHL040-019	B. WING		08/0	08/2022
	PROVIDER OR SUPPLIER SEALS UCP-GREEN	F COUNTY GROU 704 SE	ADDRESS, CITY, SECOND STR			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
V 132		ge 4 up with client #6's behavior the frequent allegations of	V 132			
V 367	10A NCAC 27G .06 REPORTING REQUITED CATEGORY A AND (a) Category A and level II incidents, existe provision of billic consumer is on the incidents and level to whom the provide 90 days prior to the responsible for the services are provide becoming aware of be submitted on a f Secretary. The rep in person, facsimile means. The report information: (1) reporting identification inform (2) client ider (3) type of incident (4) description (5) status of the cause of the incider (6) other individent (6) other individent (6) category A and missing or incomples shall submit an upd report recipients by day whenever:	JIREMENTS FOR B PROVIDERS B providers shall report all acept deaths, that occur during the services or while the providers premises or level and deaths involving the clients are rendered any service within incident to the LME catchment area where and within 72 hours of the incident. The report shall or may be submitted via may or encrypted electronic shall include the following provider contact and ation; attification information; and widuals or authorities notified. B providers shall explain and the information. The provide ated report to all required the end of the next business.	III n III iii,			
	(1) the provid	er has reason to believe that				

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STATE FORM 6899 QEK811 If continuation sheet 5 of 14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED			
		MHL040-019		B. WING		08/	08/08/2022	
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
EASTER	SEALS UCP-GREEN	E COUNTY GROL		ECOND STRI LL, NC 2858				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE YMUST BE PRECEDED BY SC IDENTIFYING INFORM	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE	
V 367	information provide erroneous, mislead (2) the provide required on the inci unavailable. (c) Category A and upon request by the obtained regarding (1) hospital reinformation; (2) reports by (3) the provided (4) Category A and of all level III incided Mental Health, Dev Substance Abuse Substance Abus	d in the report may be ing or otherwise unreler obtains information dent form that was pureless shall subsect LME, other information the incident, including ecords including converted to the incident of the Division of the incident of the incident. Categon a copy of all level I a client death to the incident. In case of the incident of the incident. In case of the incident of a client or his living of client property or possible of the incident of a client or his living of client property or possible the incident of the	eliable; or on previously abmit, ation ag: fidential and incident. End a copy sion of es and urs of ory A II Division of es of seclusion a death 26C. End a for the vided. Provided and shall imeet the imeet the important in property in	V 367				

Division of Health Service Regulation

STATE FORM 6899 QEK811 If continuation sheet 6 of 14

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPI A. BUILDING	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		MHL040-019	B. WING		08/	08/2022
NAME OF	PROVIDER OR SUPPLIER	STREE	T ADDRESS, CITY,	STATE, ZIP CODE		
EASTER	SEALS UCP-GREEN	F COUNTY GROL	E SECOND STR			
(V4) ID	SLIMMARY STA	TEMENT OF DEFICIENCIES	V HILL, NC 285	PROVIDER'S PLAN OF	CORRECTION	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
V 367	Continued From pa	ge 6	V 367			
	incidents that occur (6) a stateme been no reportable incidents have occu meet any of the crit	red; and ent indicating that there hav incidents whenever no urred during the quarter tha eria as set forth in Paragra tule and Subparagraphs (1)	t phs			
	This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure a critical incident report was submitted to the Local Management Entity (LME) within 72 hours as required. The findings are.					
	Response Improver revealed: - No level II incident facility for client #6's staff on 07/13/22 An IRIS report ger support agency reg	2 of the North Carolina Incident System (IRIS) websited the report was created by the stallegation of abuse against the report was created by client #6's day arding client #6's allegation phome facility staff on itted on 07/18/22.	e st			
	revealed: - 45 year old female - Admission date of - Diagnoses of Mod	02/01/19.	ed			

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STATE FORM 6899 QEK811 If continuation sheet 7 of 14

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED			
		MHL040-019		B. WING		08/	08/08/2022	
	PROVIDER OR SUPPLIER	E COUNTY GROL	704 SE SE	DRESS, CITY, S ECOND STRI LL, NC 2858				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE / MUST BE PRECEDED BY SC IDENTIFYING INFORM	ES 'FULL	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE	
V 367	Behavior Support F - "Target Behavior I Making false report health and safety or perpetrated by staff seizure." - Recommendation BehaviorsIf [Clier you a story suggest or neglected her, yo definitively want to something bad is he been a lot of times that aren't true and you sure what what she insists the story will follow up with tr administrative staff well. Document any and follow up with tr recants or not. Follo procedures regardi substantiated claim Review on 08/04/22 investigation dated - "RE (regarding): F - Client #6 had a gu Department of Soci	2 of client #6's Individual dated 09/13/21 of clientionsFabricates of maltreatment, rife her or others report. Pretending to have as & Intervention/Responsible to help you in the state of the property of	revealed: ions: isks to tedly e a sponse to and tells as harmed at #6], I f ere have the things aelp. Are true?'. If v that you nome now as neglect er she and if for gation." cal intative.	V 367	DEFICIENCY			
	director (Qualified F aware that [Client # gone into her room room up. She state	sion: On 07/13 Group Professional (QP)) be 6] had alleged that so , beat her up, and to d this happened at 3 I this to the manage	ecame staff had re her 3:00am.					

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STATE FORM 6899 QEK811 If continuation sheet 8 of 14

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		MHL040-019		B. WING		08/0	08/2022
NAME OF	PROVIDER OR SUPPLIER				STATE, ZIP CODE		
EASTER	SEALS UCP-GREEN	E COUNTY GROL		ECOND STR LL, NC 2858			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORM.	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
V 367	3:00am completing not wake [Client #6 training for staff on middle of the night. Document. The ind manager asked how cleaned - she said back up. The Manathe home at 3:00am [Client #6 said this another day. 2 staff questioned - both sometified the guardia response was 'Here an ongoing issue with documented in her Support Plan). The same day." - "According to the incident as defined typical for the individual's planer occuld lead to advertice incident is typical for the individual's planer "Conclusion: Unsuented in the individual's planer occurred was notified in the individual of the individual occurred incident is typical for the individual occurred incident in the individual occurred incident is typical for the individual occurred incident i	ger was at the home fire drills with staff. I at the time. This was how to complete drills is on the Fire ividual's room was cow did they trash it if they must have clean ger told [Client #6] so no conducting the fire must have happened on shift, both staff waid this did not occur that day. The guare we go again's This iplan and her BSP (Eallegation was retraincident report Manuas an occurrence the dual and service delese effects to the individual as idea and her BSP." "ubstantiated." "and her BSP." "and her	They did as a lls in the Drill lleaned - the room is ned it she was at drill. d on vere r. Staff dian's shas been sehavior cted the ual and lat is not ivered an vidual, this lentified in sonnel ocial of abuse. Regional to use client	V 367			

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STATE FORM 6899 QEK811 If continuation sheet 9 of 14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		MHL040-019	B. WING		08/0	08/2022
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	STATE, ZIP CODE		
EASTER	SEALS UCP-GREEN	F COUNTY GROL	ECOND STR ILL, NC 2858			
(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 API DEFICIENCY)	IOULD BE	(X5) COMPLETE DATE
V 367	Continued From pa	ge 9	V 367			
		up with client #6's behavior dress client #6's frequent eatment.				
V 500	27D .0101(a-e) Clie	ent Rights - Policy on Rights	V 500			
	RESTRICTIONS AI (a) The governing assures the implem G.S. 122C-65, and (b) The governing implement policy to (1) all instance abuse, neglect or exported to the Couservices as specific G.S. 7A, Article 44; (2) procedure instituted in accordary practice when a meropresent serious risk Particular attention neuroleptic medical (c) In addition to the 10A NCAC 27E .01 each facility shall detend that identifies: (1) any restriction prohibited from use (2) in a 24-hounder which staff at the rights of a client (d) If the governing restrictive interventit the restrictions of cl 122C-62(b) and (d) identify:	body shall develop and assure that: ses 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 ence with sound medical edication that is known to a to the client is prescribed. It is prescribed, shall be given to the use of tions. I ose 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				

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STATE FORM 6899 QEK811 If continuation sheet 10 of 14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		MHL040-019		B. WING		08/	08/2022
	PROVIDER OR SUPPLIER SEALS UCP-GREEN	E COUNTY GROL	704 SE SI	DRESS, CITY, S ECOND STRI LL, NC 2858			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORM	ES 'FULL	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
V 500	the client; and (3) the due p involuntary client wi restrictive interventi (e) If restrictive interventi within the facility, th develop and impler compliance with Su which includes: (1) the design has been trained ar competence to use provide written auth restrictive interventi renewed for up to a accordance with the NCAC 27E .0104(e (2) the design responsible for revi interventions; and (3) the establ appeal for the resol	dual responsible for increase procedures from the refuses the use comes. The reventions are allowed a governing body shall be the policy that assubchapter 27E, Sectionation of an individual who has demonstructive interventionization for the use fons when the originate time limits specifie	or an of ed for use hall lires on .0100, al, who trated ons, to e of al order is d in 10A al to be estrictive s for ement	V 500			
	governing body faile abuse to Departme	et as evidenced by: view and interviews, ed to report an alleg nt of Social Services e audited clients (#6)	ation of s (DSS)				
	Response Improve revealed:	2 of the North Caroli ment System (IRIS) t report was created	website				

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STATE FORM G899 QEK811 If continuation sheet 11 of 14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		MHL040-019		B. WING		08/	08/2022
	PROVIDER OR SUPPLIER	E COUNTY GROL	704 SE SI	DRESS, CITY, S ECOND STRI LL, NC 2858			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE / MUST BE PRECEDED BY SC IDENTIFYING INFORM	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
V 500	facility for client #6's staff on 07/13/22. - An IRIS report ger support agency regabuse against grou 07/15/22 and submore regarder of the support of the s	s allegation of abuse herated by client #6's all p home facility staff itted on 07/18/22. 2 of client #6's Individual dated 09/13/21 DefinitionsFabricates of maltreatment, refer or others report. Pretending to have seen the second of the second day supports. 2 of a facility internal of the individual day of the individual d	s day egation of on dualized revealed: ions: isks to tedly e a sponse to and tells as harmed at #6], I f ere have true?'. If y that you nome now as neglect er she and if for gation." cal intative.	V 500			

Division of Health Service Regulation

STATE FORM 6899 QEK811 If continuation sheet 12 of 14

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: COM-	MHL040-019 ER STREET A FINE COUNTY GROU	MHL040-019 A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED 08/08/2022		
MHL040-019 B. WING 08	ER STREET A 704 SE	MHL040-019 B. WING	08/08/2022		
	ER STREET A 704 SE		08/08/2022		
NAME OF PROVIDER OR OURS USE	FNE COUNTY GROU 704 SE	IER STREET ADDRESS CITY STATE ZIP CODE	00/00/2022		
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	ENE COUNTY GROI	STREET ABBREOG, OTT 1, OTATE, ZII GOBE			
EASTER SEALS UCP-GREENE COUNTY GROL 704 SE SECOND STREET	FIAT COCIALL CIVOR				
SNOW HILL, NC 28580	SNOW	SNOW HILL, NC 28580			
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) SUMMARY STATEMENT OF DEFICIENCY IDENTIFYING INFORMATION PREFIX TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	NCY MUST BE PRECEDED BY FULL	ENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE	ON SHOULD BE COMPLETE E APPROPRIATE DATE		
V 500 Continued From page 12 V 500	page 12	n page 12 V 500			
- "Overview Discussion: On 07/13 Group Home director (Qualified Professional (QP)) became aware that [Client #6] had alleged that staff had gone into her room, beat her up, and tore her room up. She stated this happened at 3:00am. She communicated this to the manager (QP) at 7:30am. The manager was at the home at 3:00am completing fire drills with staff. They did not wake (Client #6) at the time. This was a training for staff on how to complete drills in the middle of the night. This is on the Fire Drill Document. The individual's room was cleaned - manager asked how did they trash it if the room is cleaned - she said they must have cleaned it back up. The Manager told (Client #6) she was at the home at 3:00am conducting the fire drill. [Client #6 said this must have happened on another day. 2 staff on shift, both staff were questioned - both said this did not occur. Staff notified the guardian that day. The guardian's response was 'Here we go again' - This has been an ongoing issue with (Client #6). This is documented in her plan and her BSP (Behavior Support Plan). The allegation was retracted the same day." - "According to the incident report Manual and incident as defined as an occurrence that is not typical for the individual and service delivered an could lead to adverse effects to the individual. this incident is typical for the individual as identified in the individual's plan and her BSP." - "Conclusion: Unsubstantiated." - No documentation the HCPR and the local Department of Social Services was notified of the allegation of abuse. Interview on 08/04/22 and 08/08/22 the Regional Director stated: - Client #6 had a history of making false	cussion: On 07/13 Group Home ed Professional (QP)) became int #6] had alleged that staff had om, beat her up, and tore her ated this happened at 3:00am. Inted this to the manager (QP) at anager was at the home at ing fire drills with staff. They did #6] at the time. This was a on how to complete drills in the individual's room was cleaned how did they trash it if the room aid they must have cleaned it anager told [Client #6] she was a community of the individual's room was cleaned how did they trash it if the room aid they must have cleaned it anager told [Client #6] she was a community of the individual in the interest of the individual in the individual in the BSP (Behavior The allegation was retracted the incident report Manual and ited as an occurrence that is not dividual and service delivered and verse effects to the individual. The individual as identified in the HCPR and the local social Services was notified of the incident Services was notified Services was notified Services was notified Service	iccussion: On 07/13 Group Home ed Professional (QP)) became ent #6] had alleged that staff had som, beat her up, and tore her tated this happened at 3:00am. atted this to the manager (QP) at anager was at the home at sting fire drills with staff. They did tt #6] at the time. This was a f on how to complete drills in the gight This is on the Fire Drill individual's room was cleaned - I how did they trash it if the room is aid they must have cleaned it lanager told [Client #6] she was at 100am conducting the fire drill. This must have happened on staff on shift, both staff were oth said this did not occur. Staff rudian that day. The guardian's Here we go again' - This has been us with [Client #6]. This is her plan and her BSP (Behavior The allegation was retracted the the incident report Manual and ned as an occurrence that is not ndividual and service delivered and the day and service delivered and the day are serviced elivered and the service of the individual. This al for the individual as identified in plan and her BSP." Jusubstantiated." ation the HCPR and the local Social Services was notified of the use. //04/22 and 08/08/22 the Regional			

allegations of abuse against staff.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		
		MHL040-019		B. WING		08/	08/2022
	PROVIDER OR SUPPLIER	F COUNTY GROU	704 SE SE	DRESS, CITY, SECOND STR			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY F SC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
V 500	- Client #6 had a be address the allegat - The 07/13/22 incid #6 retracted her alle - She knew a DSS to the facility to invehad made Client #6 had retraces - She understood the	chavior support plan to ions. dent was short because egation. representative had co estigate an allegation of acted her allegation. he facility was required of all allegations of a	se client ome out client #6	V 500			

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