STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL0601458	B. WING		08	8/15/2022
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	ZIP CODE		
	KE FAMILY		LD BRIDGE LANE OTTE, NC 28269			
(X4) ID	SUMMARY ST			PROVIDER'S PLAN OF	F CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	COMPLETI
V 000	INITIAL COMMENTS		V 000			
	An annual and complaint survey was competed on 8-15-22. The complaint was substantiated (NC00190437). Deficiencies were cited.					
	This facility is licensed for the following service category: 10A NCAC 27G 5600F Supervised Living for All Disabilities in a Private Residence.					
	a census of one. The	d for three and currently has survey sample consisted of current client and one former				
V 108	27G .0202 (F-I) Perso	onnel Requirements	V 108			
	10A NCAC 27G .0202 PERSONNEL REQUIREMENTS (f) Continuing education shall be documented.					
	following:	nimum, shall consist of the				
		tional orientation; rights and confidentiality as AC 27C, 27D, 27E, 27F and				
	client as specified in t plan; and	he mh/dd/sa needs of the he treatment/habilitation				
	.,					
		ilable in the facility at all present. That staff				
	including seizure mar to provide cardiopulm	nagement, currently trained nonary resuscitation and h maneuver or other first aid				
	techniques such as th	nose provided by Red Cross,				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: MHL0601458					(X3) DATE SURVEY COMPLETED	
		B. WING		08/15/2022		
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE,	, ZIP CODE		
REAT LI	KE FAMILY		LD BRIDGE LANE DTTE, NC 28269			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 108	Continued From page	e 1	V 108			
	(i) The governing bo implement policies at reporting, investigatir	ving airway obstruction.				
	facility failed to ensur	ews and interviews the re one of one audited natural training to meet the needs				
	-Diagnoses of In Disorder, Generalize Intellectual Disability Strabismus, Microce Depression, Stroke, S -Treatment Plan	Seizure Disorder. dated 11-1-21 revealed;				
	when upset, follow so check mailbox daily, motor activity daily, r g-tube, tolerate assis bathroom. -Goals stated that	at a natural support would be				
	-Criminal backgr 19.	goals. f NS#1's record revealed: round check completed 10-4- ion of training completed.				

D STATE FORM

STATEMENT OF DEFICIENCIES (AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			E SURVEY PLETED	
	MHL0601458		B. WING		08	08/15/2022	
NAME OF P	ROVIDER OR SUPPLIER	STREET	DDRESS, CITY, STATE	, ZIP CODE			
TREAT LI	KE FAMILY						
			DTTE, NC 28269				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETI DATE	
V 108	Continued From page	e 2	V 108				
	-She had known	with the NS#1 revealed: Client #1 for years. he school system and was					
	Living (AFL) provider -She had Client # -He does have a him out temporaily du -During the day (her daughter. -Her daughter wa	#2 for 11 years. day program, but she took le to Covid. Client #2 was at home with as a natural support and she they had grown up together					
	going to the day prog	d: re the Client #1 hadn't been					
V 110	27G .0204 Training/S Paraprofessionals	Supervision	V 110				
	SUPERVISION OF P. (a) There shall be no paraprofessionals. (b) Paraprofessionals associate professional professional as specif Subchapter. (c) Paraprofessionals knowledge, skills and population served. (d) At such time as a	fied in Rule .0104 of this s shall demonstrate abilities required by the					

Division of Health Service Regulation STATE FORM

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AND PLAN OF CORRECTION IDENTIFICATION N		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	R: A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL0601458	B. WING		08	/15/2022
NAME OF PI	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE	, ZIP CODE		
REAT LI	KE FAMILY		LD BRIDGE LANE OTTE, NC 28269			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE
V 110	Continued From page	e 3	V 110			
V 110	 continued From page 3 then qualified professionals and associate professionals shall demonstrate competence. (e) Competence shall be demonstrated by exhibiting core skills including: (1) technical knowledge; (2) cultural awareness; (3) analytical skills; (4) decision-making; (5) interpersonal skills; (6) communication skills; and (7) clinical skills. (f) The governing body for each facility shall develop and implement policies and procedures for the initiation of the individualized supervision plan upon hiring each paraprofessional. 					
	one Alternative Fami to demonstrate know	as evidenced by: and record reviews one of ly Living (AFL) provider failed rledge, skills and ability lation served. The findings				
	#1's legal guardian/m "She (AFL pro his June room and be	ovider) fraudulently deposited oard check that was sent via t mailed the check his last				
		-				

Division of Health Service Regulation STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			
		MHL0601458	B. WING	·····	08	8/15/2022
AME OF PF	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE,	ZIP CODE		
	KE FAMILY		LD BRIDGE LANE OTTE, NC 28269			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE
V 110	Continued From pag	e 4	V 110			
	 not live there anymore. She put a stop on the check and she thinks the AFL provider's bank charged her a fee, which angered the AFL provider. Interview on 7-11-22 with the AFL provider revealed: She had tried to cash the June check, but the mother had put a stop on it. "I deposited, but it was stopped payment I guess she has the check." She had to get a professional company to clean her house after Former Client #1 attacked her so she wanted him to pay for that. She also lost a pair of earrings during the attack, and Former Client #1 owed her money for throwing food away. 					