

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL080-164	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 08/18/2022
NAME OF PROVIDER OR SUPPLIER CABARRUS COUNTY GROUP HOME 5		STREET ADDRESS, CITY, STATE, ZIP CODE 106 SOUTH FRANKLIN STREET CHINA GROVE, NC 28023		
(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>INITIAL COMMENTS</p> <p>A complaint and follow up survey was completed on 8/18/22. The complaints were substantiated (intake #NC00191471 and #NC00191474). Deficiencies were cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities</p> <p>This facility is licensed for 5 and currently has a census of 5. The survey sample consisted of audits of 5 current clients.</p>	V 000		
V 318	<p>130 .0102 HCPR - 24 Hour Reporting</p> <p>10A NCAC 130 .0102 INVESTIGATING AND REPORTING HEALTH CARE PERSONNEL The reporting by health care facilities to the Department of all allegations against health care personnel as defined in G.S. 131E-256 (a)(1), including injuries of unknown source, shall be done within 24 hours of the health care facility becoming aware of the allegation. The results of the health care facility's investigation shall be submitted to the Department in accordance with G.S. 131E-256(g).</p> <p>This Rule is not met as evidenced by: Based on interview and record review, the facility failed to notify Health Care Personnel Registry (HCPR) within 24 hours of learning about all</p>	V 318		

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: MHL080-164	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R-C 08/18/2022
NAME OF PROVIDER OR SUPPLIER CABARRUS COUNTY GROUP HOME 5			STREET ADDRESS, CITY, STATE, ZIP CODE 106 SOUTH FRANKLIN STREET CHINA GROVE, NC 28023		
(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 318	Continued From page 1 allegations of abuse affecting 1 of 1 audited former staff (FS) #3. The findings are: Review on 8/10/22 of the HCPR Initial Allegation Report revealed: - "Incident Date April 1, 2022" - "Date Facility Became Aware of Incident April 1, 2022 at 10:29am reported to administrator" - HCPR Initial Allegation Report was faxed on 4/5/22 to the HCPR. Interview on 8/17/22 with the former Qualified Professional revealed: - She reported the 4/1/22 incident on 4/5/22, because she was unsure if she needed to file the HCPR report. - "I now know better. That was an agency you needed to have permission to do reporting. I waited too long to ask [the Administrator]. That is entirely on me."	V 318			
V 366	27G .0603 Incident Response Requirments 10A NCAC 27G .0603 INCIDENT RESPONSE REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall develop and implement written policies governing their response to level I, II or III incidents. The policies shall require the provider to respond by: (1) attending to the health and safety needs of individuals involved in the incident; (2) determining the cause of the incident; (3) developing and implementing corrective measures according to provider specified timeframes not to exceed 45 days; (4) developing and implementing measures to prevent similar incidents according to provider specified timeframes not to exceed 45 days;	V 366			

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL080-164	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 08/18/2022
NAME OF PROVIDER OR SUPPLIER CABARRUS COUNTY GROUP HOME 5		STREET ADDRESS, CITY, STATE, ZIP CODE 106 SOUTH FRANKLIN STREET CHINA GROVE, NC 28023		
(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 366	Continued From page 2 (5) assigning person(s) to be responsible for implementation of the corrections and preventive measures; (6) adhering to confidentiality requirements set forth in G.S. 75, Article 2A, 10A NCAC 26B, 42 CFR Parts 2 and 3 and 45 CFR Parts 160 and 164; and (7) maintaining documentation regarding Subparagraphs (a)(1) through (a)(6) of this Rule. (b) In addition to the requirements set forth in Paragraph (a) of this Rule, ICF/MR providers shall address incidents as required by the federal regulations in 42 CFR Part 483 Subpart I. (c) In addition to the requirements set forth in Paragraph (a) of this Rule, Category A and B providers, excluding ICF/MR providers, shall develop and implement written policies governing their response to a level III incident that occurs while the provider is delivering a billable service or while the client is on the provider's premises. The policies shall require the provider to respond by: (1) immediately securing the client record by: (A) obtaining the client record; (B) making a photocopy; (C) certifying the copy's completeness; and (D) transferring the copy to an internal review team; (2) convening a meeting of an internal review team within 24 hours of the incident. The internal review team shall consist of individuals who were not involved in the incident and who were not responsible for the client's direct care or with direct professional oversight of the client's services at the time of the incident. The internal review team shall complete all of the activities as follows: (A) review the copy of the client record to	V 366		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL080-164	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 08/18/2022
NAME OF PROVIDER OR SUPPLIER CABARRUS COUNTY GROUP HOME 5		STREET ADDRESS, CITY, STATE, ZIP CODE 106 SOUTH FRANKLIN STREET CHINA GROVE, NC 28023		
(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 366	Continued From page 3 determine the facts and causes of the incident and make recommendations for minimizing the occurrence of future incidents; (B) gather other information needed; (C) issue written preliminary findings of fact within five working days of the incident. The preliminary findings of fact shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different; and (D) issue a final written report signed by the owner within three months of the incident. The final report shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different. The final written report shall address the issues identified by the internal review team, shall include all public documents pertinent to the incident, and shall make recommendations for minimizing the occurrence of future incidents. If all documents needed for the report are not available within three months of the incident, the LME may give the provider an extension of up to three months to submit the final report; and (3) immediately notifying the following: (A) the LME responsible for the catchment area where the services are provided pursuant to Rule .0604; (B) the LME where the client resides, if different; (C) the provider agency with responsibility for maintaining and updating the client's treatment plan, if different from the reporting provider; (D) the Department; (E) the client's legal guardian, as applicable; and (F) any other authorities required by law.	V 366		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL080-164	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 08/18/2022
NAME OF PROVIDER OR SUPPLIER CABARRUS COUNTY GROUP HOME 5		STREET ADDRESS, CITY, STATE, ZIP CODE 106 SOUTH FRANKLIN STREET CHINA GROVE, NC 28023		
(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 366	<p>Continued From page 4</p> <p>This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to report a Level II incident to the client's legal guardian as required. The findings are:</p> <p>Review on 8/10/22 of the Incident Response Improvement System (IRIS) revealed:</p> <ul style="list-style-type: none"> - Date of incident: 4/1/22 - "Consumer's Name: [Client #5]" - "On April 1, community members from [local county] went to [Day Program that Clients #1- #5 attended] to report that they were at the [restaurant] in [city] and were there eating. They reported a manager of a group home (former staff (FS) #3) was using profanity and seemingly threatening language. This was reported to [the Day Program (DP)] as one person they overheard at the restaurant refer to [the day Program]. The report was taken by the ED (Executive Director) at [the Day Program], [DPED]. The only name [DPED] got from the couple was [first name of the 1st community member] and [first name of the 2nd community member] with no other information. [DPED] looked at the photo that one of the community members took and saw that it was a person that worked for Cabarrus County Group Homes, Inc (Licensee). He directed the community members to report this information at our office. The community members came to the office on [local road]. They asked to speak to [administrator], the administrator. They were told that [administrator] would not be in the office that day. The community members said they would 	V 366		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL080-164	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 08/18/2022
NAME OF PROVIDER OR SUPPLIER CABARRUS COUNTY GROUP HOME 5		STREET ADDRESS, CITY, STATE, ZIP CODE 106 SOUTH FRANKLIN STREET CHINA GROVE, NC 28023		
(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 366	<p>Continued From page 5</p> <p>be back on Monday, April 4. The community members did not come back on the 4th, or the 5th. An investigation with the residents who were at the restaurant that day (clients #1- #5) with the group home manager (FS #3) that the allegations were about."</p> <p>- "[Client #5] was asked about her breakfast at [restaurant]. She was asked if anything unusual got said by the staff person. She said that she (FS #3) yelled at us and cussed at us. She used the "S" work and the "F" word. She told me to eat all my food. She said another resident got up to go pay her bill and the manager started yelling at us, but she couldn't remember why. [Client #5] also said that the manager (FS #3) called her retarded. When asked if anything unusual, or strange happened, or if there were any arguments, she said no, that there was no arguing among the residents. When asked if she had a good time while there she said yes, I kept my mouth shut. When asked if she wanted to tell us about anything else that happened that morning at the restaurant, she said no."</p> <p>Review on 8/10/22 of the IRIS revealed:</p> <p>- Date of incident: 4/1/22</p> <p>- "Consumer's Name: [Client #1]"</p> <p>- "When [client #1] was asked about his breakfast at [restaurant] he was asked if anything unusual get said by the staff person? He said that he was called retarded in front of everyone. When asked if anything else was said that was strange, arguments, or yelling, [Client #1] responded that the group home manager (FS #3) was yelling but he didn't remember what it was that she was yelling and that he couldn't remember anything else when asked if he wanted to tell anything else that happened while he was there. When asked if he had a good time while there he said yes."</p>	V 366		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL080-164	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 08/18/2022
NAME OF PROVIDER OR SUPPLIER CABARRUS COUNTY GROUP HOME 5		STREET ADDRESS, CITY, STATE, ZIP CODE 106 SOUTH FRANKLIN STREET CHINA GROVE, NC 28023		
(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 366	Continued From page 6 Interview on 8/11/22 with client #1's legal guardian (LG) revealed: - The group home never notified her about the 4/1/22 incident. Interview on 8/11/22 with client #3's LG revealed: - She was not notified by the group home about the 4/1/22 incident. - "I heard nothing from the group home, and they did not report it to me. [The administrator] never notified me about the incident." Attempted interview on 8/12/22 with client #2's LG: - Left voicemail message. Never received a return call. Interview on 8/12/22 with the Qualified Professional revealed: - She notified 2 of the 5 legal guardians because the other 3 clients had not disclosed information to her. - "The only two legal guardians who were spoken to were the two (clients) who disclosed information."	V 366		
V 367	27G .0604 Incident Reporting Requirements 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall report all level II incidents, except deaths, that occur during the provision of billable services or while the consumer is on the providers premises or level III incidents and level II deaths involving the clients to whom the provider rendered any service within 90 days prior to the incident to the LME responsible for the catchment area where	V 367		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL080-164	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 08/18/2022
NAME OF PROVIDER OR SUPPLIER CABARRUS COUNTY GROUP HOME 5		STREET ADDRESS, CITY, STATE, ZIP CODE 106 SOUTH FRANKLIN STREET CHINA GROVE, NC 28023		
(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 367	Continued From page 7 services are provided within 72 hours of becoming aware of the incident. The report shall 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	V 367		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL080-164	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 08/18/2022
NAME OF PROVIDER OR SUPPLIER CABARRUS COUNTY GROUP HOME 5		STREET ADDRESS, CITY, STATE, ZIP CODE 106 SOUTH FRANKLIN STREET CHINA GROVE, NC 28023		
(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 367	<p>Continued From page 8</p> <p>providers shall send a copy of all level III incidents involving a client death to the Division of Health Service Regulation within 72 hours of becoming aware of the incident. In cases of client death within seven days of use of seclusion or restraint, the provider shall report the death immediately, as required by 10A NCAC 26C .0300 and 10A NCAC 27E .0104(e)(18).</p> <p>(e) Category A and B providers shall send a report quarterly to the LME responsible for the catchment area where services are provided. The report shall be submitted on a form provided by the Secretary via electronic means and shall include summary information as follows:</p> <p>(1) medication errors that do not meet the definition of a level II or level III incident;</p> <p>(2) restrictive interventions that do not meet the definition of a level II or level III incident;</p> <p>(3) searches of a client or his living area;</p> <p>(4) seizures of client property or property in the possession of a client;</p> <p>(5) the total number of level II and level III incidents that occurred; and</p> <p>(6) a statement indicating that there have been no reportable incidents whenever no incidents have occurred during the quarter that meet any of the criteria as set forth in Paragraphs (a) and (d) of this Rule and Subparagraphs (1) through (4) of this Paragraph.</p> <p>This Rule is not met as evidenced by: Based on interview and record reviews, the facility failed to report all Level II incidents that</p>	V 367		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL080-164	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 08/18/2022
NAME OF PROVIDER OR SUPPLIER CABARRUS COUNTY GROUP HOME 5		STREET ADDRESS, CITY, STATE, ZIP CODE 106 SOUTH FRANKLIN STREET CHINA GROVE, NC 28023		
(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 367	Continued From page 9 occurred during the provision of billable services to the LME (Local Management Entity) within 72 hours of becoming aware of the incident. The findings are: Review on 8/10/22 of the Incident Response Improvement System (IRIS) revealed: - The incident that occurred on 4/1/22 was not submitted until 4/6/22. Review on 8/10/22 of the Incident Response Improvement System (IRIS) revealed: - There was not an incident report submitted for client #2, client #3 and client #4 regarding the 4/1/22 incident. Interview on 8/12/22 with the Qualified Professional revealed: - She did not submit the IRIS report until 5 days after the incident because she was waiting on reports including a report from the day program (note: the day program provided their report to Cabarrus County Group Home #5 on 4/1/22). She was also waiting for staff to talk to the couple who had witnessed the incident on 4/1/22. - She did not do an IRIS report for client #2, client #3 and client #4 because they "didn't have anything to report."	V 367		
V 500	27D .0101(a-e) Client Rights - Policy on Rights 10A NCAC 27D .0101 POLICY ON RIGHTS RESTRICTIONS AND INTERVENTIONS (a) The governing body shall develop policy that assures the implementation of G.S. 122C-59, G.S. 122C-65, and G.S. 122C-66. (b) The governing body shall develop and implement policy to assure that: (1) all instances of alleged or suspected abuse, neglect or exploitation of clients are	V 500		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL080-164	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 08/18/2022
NAME OF PROVIDER OR SUPPLIER CABARRUS COUNTY GROUP HOME 5		STREET ADDRESS, CITY, STATE, ZIP CODE 106 SOUTH FRANKLIN STREET CHINA GROVE, NC 28023		
(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 500	Continued From page 10 reported to the County Department of Social Services as specified in G.S. 108A, Article 6 or G.S. 7A, Article 44; and (2) procedures and safeguards are instituted in accordance with sound medical practice when a medication that is known to present serious risk to the client is prescribed. Particular attention shall be given to the use of neuroleptic medications. (c) In addition to those procedures prohibited in 10A NCAC 27E .0102(1), the governing body of each facility shall develop and implement policy that identifies: (1) any restrictive intervention that is prohibited from use within the facility; and (2) in a 24-hour facility, the circumstances under which staff are prohibited from restricting the rights of a client. (d) If the governing body allows the use of restrictive interventions or if, in a 24-hour facility, the restrictions of client rights specified in G.S. 122C-62(b) and (d) are allowed, the policy shall identify: (1) the permitted restrictive interventions or allowed restrictions; (2) the individual responsible for informing the client; and (3) the due process procedures for an involuntary client who refuses the use of restrictive interventions. (e) If restrictive interventions are allowed for use within the facility, the governing body shall develop and implement policy that assures compliance with Subchapter 27E, Section .0100, which includes: (1) the designation of an individual, who has been trained and who has demonstrated competence to use restrictive interventions, to provide written authorization for the use of	V 500		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL080-164	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 08/18/2022
NAME OF PROVIDER OR SUPPLIER CABARRUS COUNTY GROUP HOME 5		STREET ADDRESS, CITY, STATE, ZIP CODE 106 SOUTH FRANKLIN STREET CHINA GROVE, NC 28023		
(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 500	Continued From page 11 restrictive interventions when the original order is renewed for up to a total of 24 hours in accordance with the time limits specified in 10A NCAC 27E .0104(e)(10)(E); (2) the designation of an individual to be responsible for reviews of the use of restrictive interventions; and (3) the establishment of a process for appeal for the resolution of any disagreement over the planned use of a restrictive intervention. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure allegations of abuse were reported to the County Department of Social Services (DSS) affecting 5 of 5 clients (clients #1 - #5). The findings are: Review on 8/10/22 of the Incident Response Improvement System (IRIS) revealed: - Date of Incident: 4/1/22 - DSS had not been notified about the incident. Interview on 8/17/22 with the Qualified Professional revealed: - She talked to Client #1's DSS legal guardian about the incident, but she did not make a report to Adult Protective Services Intake.	V 500		
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.	V 512		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL080-164	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 08/18/2022
NAME OF PROVIDER OR SUPPLIER CABARRUS COUNTY GROUP HOME 5		STREET ADDRESS, CITY, STATE, ZIP CODE 106 SOUTH FRANKLIN STREET CHINA GROVE, NC 28023		
(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 12</p> <p>(b) Employees shall not subject a client to any sort of abuse or neglect, as defined in 10A NCAC 27C .0102 of this Chapter.</p> <p>(c) Goods or services shall not be sold to or purchased from a client except through established governing body policy.</p> <p>(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.</p> <p>(e) Any violation by an employee of Paragraphs (a) through (d) of this Rule shall be grounds for dismissal of the employee.</p> <p>This Rule is not met as evidenced by: Based on record reviews, interviews, and observations, 1 of 1 (former staff (FS) #3) abused 5 of 5 clients (clients #1 - #5). The findings are:</p> <p>Review on 8/10/22 of FS #3's record revealed: - Hire Date: 3/2/15 - Date of Separation: 4/1/22 - A degree and work history that qualified her as a Paraprofessional.</p> <p>Review on 8/11/22 of client #1's record revealed: - Admission date: 2/7/19 - Diagnoses: Severe Intellectual Disability and Speech Sound Disorder - Review of client #1's psychological evaluation dated 8/29/20 revealed: full scale intelligence quotient (FSIQ) of 43</p>	V 512		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL080-164	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 08/18/2022
NAME OF PROVIDER OR SUPPLIER CABARRUS COUNTY GROUP HOME 5		STREET ADDRESS, CITY, STATE, ZIP CODE 106 SOUTH FRANKLIN STREET CHINA GROVE, NC 28023		
(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 13</p> <p>Review on 8/10/22 of client #2's record revealed:</p> <ul style="list-style-type: none"> - Admission date: 7/1/07 - Diagnoses: Oppositional Disorder; Autistic Disorder and Mild Intellectual and Developmental Disabilities (IDD) - Review of client #2's treatment plan dated 12/1/21 revealed: "[Client #2] has limited communication ..." - Review of client #2's psychological evaluation dated 10/21/13 revealed: FSIQ of 51 <p>Review on 8/10/22 of client #3's record revealed:</p> <ul style="list-style-type: none"> - Admission date: 7/1/07 - Diagnosis: Moderate Intellectual Disability - Review of client #3's treatment plan dated 12/9/21 revealed: "Be aware that [client #3] can easily be taken advantage of by others who may feel that [client #3] is an easy target as he could be vulnerable to being exploited by others because of his easy-going nature and expressing his thoughts and concerns do not always come easily for him. Also, others could tend to boss him and he would not defend himself." - Review of client #3's psychological evaluation dated 9/9/13 revealed: FSIQ of 45 <p>Review on 8/10/22 of client #4's record revealed:</p> <ul style="list-style-type: none"> - Admission date: 7/1/07 - Diagnosis: Mild Intellectual Disabilities - Review of client #4's psychological evaluation dated 9/30/13 revealed: FSIQ of 65 <p>Review on 8/10/22 of client #5's record revealed:</p> <ul style="list-style-type: none"> - Admission date: 6/1/16 - Diagnoses: Mild IDD and Major Depression - Review of client #5's psychological evaluation dated 3/19/15 revealed: FSIQ of 69 <p>Interview on 8/10/22 with the Day Program</p>	V 512		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL080-164	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 08/18/2022
NAME OF PROVIDER OR SUPPLIER CABARRUS COUNTY GROUP HOME 5		STREET ADDRESS, CITY, STATE, ZIP CODE 106 SOUTH FRANKLIN STREET CHINA GROVE, NC 28023		
(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 14</p> <p>Executive Director (DPED) revealed:</p> <ul style="list-style-type: none"> - All the clients (#1 - #5) who resided at the Cabarrus County Group Home #5 attended the Day Program. - On 4/1/22 an unknown couple were in the Day Program lobby and wanted to speak to the person in charge. The couple asked to speak to him outside. - The couple had just come from a restaurant and provided him with a picture of the Cabarrus County Group Home #5 clients and a staff. The couple thought the staff person worked at the Day Program, but he did not recognize the staff person in the picture. He later learned the staff person worked at the Cabarrus County Group Home #5 and was FS #3. - The couple reported to him "[FS #3] had used profanity at the clients and raised her voice. They said a lot of folks in the restaurant were staring because the lady (FS #3) was so loud and telling the clients to sit down in a loud voice and was talking down to clients and using profanity." - He provided the couple with the address to the Cabarrus County Group Home #5's office and provided the couple with the name of the group home administrator. - He only knew the first names of the couple and did not get their last name or phone number. - He instructed the Day Program Qualified Professional (DPQP) to do interviews with all 5 clients and submit her findings to IRIS (Incident Response Improvement System). - He was present during the interviews with the clients. - He contacted the Cabarrus County Group Home #5 Administrator and told her what he learned and that he was not going to allow FS #3 to pick up the clients that day. - "They (clients) were afraid if they said anything that [FS #3] would retaliate. All clients except for 	V 512		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL080-164	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 08/18/2022
NAME OF PROVIDER OR SUPPLIER CABARRUS COUNTY GROUP HOME 5		STREET ADDRESS, CITY, STATE, ZIP CODE 106 SOUTH FRANKLIN STREET CHINA GROVE, NC 28023		
(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 15</p> <p>[client #2] and maybe [client #3] said they were all afraid of her and did not feel safe."</p> <p>- "Especially after we heard their statements and what happened I felt it was verbal abuse."</p> <p>- "We have had different discussions with these clients and other clients (and told the clients) if they are feeling uncomfortable or unsafe to talk to the QP (Qualified Professional) or me. These clients knew they were supposed to come and tell but they were too afraid to tell."</p> <p>Review on 8/9/22 of the IRIS revealed:</p> <p>- The Day Program that clients #1- #5 attended submitted the following IRIS report on 4/1/22: "At approximately 10am, two members of the community came to [the Day Program] after eating breakfast at the [restaurant]...They reported to Executive Director (the DPED) ...that a staff member (FS #3) was directing profanity and threatening language towards the clients. They reported that they overheard that the individuals were part of [the Day Program]. Assuming the staff member worked her, they reported it [the Day Program]. The individuals reported that restaurant patrons were staring because of the loud and disrespect language towards the individuals. Pictures were shown [DPED] confirming the exact group home residents. [The DPED] confirmed that individuals were wearing the same clothing as in the picture to identify that it was in fact today. [DPED] contacted [the Administrator], Executive Director of Cabarrus County Group Homes, to notify her of the situation and discuss that the individuals ([first names of the two members of the community]) would be coming to give their statement directly to staff at the office. [The Administrator] discussed arranging for another staff member to pick the clients up from [the Day Program] this afternoon.</p>	V 512		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL080-164	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 08/18/2022
NAME OF PROVIDER OR SUPPLIER CABARRUS COUNTY GROUP HOME 5		STREET ADDRESS, CITY, STATE, ZIP CODE 106 SOUTH FRANKLIN STREET CHINA GROVE, NC 28023		
(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 16 [DPQP] and [DPED] discussed that interviews would be conducted with all individuals that were at [restaurant] at the time of the alleged incident. [DPQP], [DPED] and [the DP staff], proceeded to interview all individuals that were at breakfast before arriving at [the Day Program]. [Client #4]- The individual confirmed that they ate breakfast at [restaurant] before arriving to [the Day Program]. She asked if the group home manager (FS #3) would find out that she talked to [the Day Program] staff. She said, 'She'll come back on me.' [Client #4] stated that she didn't hear cussing because she 'must have been at the register to pay.' She did hear the home manager tell [Client #5] 'Put your coffee down!' Individual also said that she heard manager say to [Client #5], 'If you don't eat all of your food, you are going to get a kid's plate next time.' She then discussed her fear of the home manager in other situations. She discussed that the manager hit [Client #5] in the back and face, but could not recall the date it happened. [Client #4] also said she had previously hit the group home manager and that the manager hit her back. [Client #4] then said the manager responded 'I will throw you through the window if you hit me again.' She then said that she was scared of her. [Client #1]- The individual confirmed eating at [restaurant]. Individual stated that the group home manager used curse words towards the residents. However, he did not remember the exact words. He stated that the manager had previously hit [Client #5] in the back and face. Individual did not remember when this happened. [Client #1] reported that manager previously slapped him during a beach trip (incident previously reported). He said 'To tell you the truth, I don't feel safe.' Individual stated that the manager is 'wild.' It was asked for him to clarify what this meant. Individual stated that she is loud,	V 512		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL080-164	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 08/18/2022
NAME OF PROVIDER OR SUPPLIER CABARRUS COUNTY GROUP HOME 5		STREET ADDRESS, CITY, STATE, ZIP CODE 106 SOUTH FRANKLIN STREET CHINA GROVE, NC 28023		
(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 17</p> <p>yells, and calls them names like retarded. He stated that he doesn't like that word being used. [Client #5]- Individual reported that group home manager has a 'bad temper.' Individual reported that manager yelled during breakfast, used the F word, and said, 'If you don't eat all of your food, I'm gonna choke you,' 'Eat your f*****g food,' and 'Put your G*d D**n coffee down.' She stated that she was scared of her. She did not want manager to know she had talked to [the Day Program] staff. She stated that manager had slapped her previously on the face when she didn't turn the water off in the kitchen sink. At the restaurant, individual stated that manager called all of the residents retarded. Individual said she didn't like that word.</p> <p>[Client #2]- Individual said she ate at [restaurant] and described what she ate for breakfast. She repeated phrases of keep your hands to self and be nice to [client #5]. It was asked if individual heard anything. Individual stated, 'Put that cup down and eat.' Individual kept repeating various phrases.</p> <p>[Client #3]- Individual stated that he ate breakfast. Individual kept saying, '[Client #5] did it, [FS #3] was mean.' He did not clarify what this meant. Individual said 'Put that cup down!' Individual stated [Client #5] cussed at [FS #3]. It was asked if individual had ever seen her be mean. Individual repeated, 'Hit [client #5] on the arm with her fist.' He modeled it to [the Day Program] staff twice."</p> <p>- "Incident Prevention: [DPED] ...ensured that individuals would not be leaving the program with the alleged abuser. [The Day Program] staff will continue to report any allegations of abuse or neglect to the appropriate agencies to ensure the safety of all individuals."</p> <p>Review on 8/10/22 of the IRIS revealed:</p>	V 512		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL080-164	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 08/18/2022
NAME OF PROVIDER OR SUPPLIER CABARRUS COUNTY GROUP HOME 5		STREET ADDRESS, CITY, STATE, ZIP CODE 106 SOUTH FRANKLIN STREET CHINA GROVE, NC 28023		
(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 18</p> <ul style="list-style-type: none"> - Date of incident: 4/1/22 - Name of Person completing report: the QP at Cabarrus County Group Home #5 - "Consumer's Name: [Client #5]" - "On April 1, community members from [local county] went to [Day Program that Clients #1- #5 attended] to report that they were at the [restaurant] in [city] and were there eating. They reported a manager of a group home (former staff (FS) #3) was using profanity and seemingly threatening language. This was reported to [the Day Program (DP)] as one person they overheard at the restaurant refer to [the day Program]. The report was taken by the ED (Executive Director) at [the Day Program], [DPED]. The only name [DPED] got from the couple was [first name of the 1st community member] and [first name of the 2nd community member] with no other information. [DPED] looked at the photo that one of the community members took and saw that it was a person that worked for Cabarrus County Group Homes, Inc. He directed the community members to report this information at our office. The community members came to the office on [local road]. They asked to speak to [administrator] the administrator. They were told that [administrator] would not be in the office that day. The community members said they would be back on Monday, April 4. The community members did not come back on the 4th, or the 5th. An investigation with the residents who were at the restaurant that day (clients #1- #5) with the group home manager (FS #3) that the allegations were about." - "[Client #5] was asked about her breakfast at [restaurant]. She was asked if anything unusual got said by the staff person. She said that she (FS #3) yelled at us and cussed at us. She used the "S" word and the "F" word. She told me to eat all my food. She said another resident got up to 	V 512		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL080-164	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 08/18/2022
NAME OF PROVIDER OR SUPPLIER CABARRUS COUNTY GROUP HOME 5		STREET ADDRESS, CITY, STATE, ZIP CODE 106 SOUTH FRANKLIN STREET CHINA GROVE, NC 28023		
(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 19</p> <p>go pay her bill and the manager started yelling at us, but she couldn't remember why. [Client #5] also said that the manager (FS #3) called her retarded. When asked if anything unusual, or strange happened, or if there were any arguments, she said no, that there was no arguing among the residents. When asked if she had a good time while there she said yes, I kept my mouth shut. When asked if she wanted to tell us about anything else that happened that morning at the restaurant, she said no."</p> <p>Review on 8/10/22 of the IRIS revealed:</p> <ul style="list-style-type: none"> - Date of incident: 4/1/22 - Name of Person completing report: the QP at Cabarrus County Group Home #5 - "Consumer's Name: [Client #1]" - "When [client #1] was asked about his breakfast at [restaurant] he was asked if anything unusual get said by the staff person? He said that he was called retarded in front of everyone. When asked if anything else was said that was strange, arguments, or yelling, [Client #1] responded that the group home manager (FS #3) was yelling but he didn't remember what it was that she was yelling and that he couldn't remember anything else when asked if he wanted to tell anything else that happened while he was there. When asked if he had a good time while there he said yes." <p>Interviews on 8/9/22 and 8/10/22 with client #1 revealed:</p> <ul style="list-style-type: none"> - FS #3 called him and the other clients (#2 - #5) names when they were at a local restaurant on 4/1/22. FS #3 was the only staff at the restaurant. FS #3 also yelled at the clients while at the restaurant. - "[FS #3] called us retarded in front of everybody at the restaurant ... She also called all of us stupid at the [local restaurant] in front of 	V 512		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL080-164	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 08/18/2022
NAME OF PROVIDER OR SUPPLIER CABARRUS COUNTY GROUP HOME 5		STREET ADDRESS, CITY, STATE, ZIP CODE 106 SOUTH FRANKLIN STREET CHINA GROVE, NC 28023		
(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 20</p> <p>everyone. She also called us b*****ds, all of us in front of everyone. She was yelling her words to all of us."</p> <ul style="list-style-type: none"> - "I was afraid of [FS #3]." - "[FS #3] was all the time yelling at me." - "The entire time [FS #3] worked there she was yelling, screaming at us." - "[FS #3] was mean to us. She hollered to me all the time and called me retarded or stupid all the time." - After the clients left the restaurant, FS #3 dropped the clients off at the Day Program. Then the clients talked to the staff at the Day Program about what occurred at the restaurant. <p>Interviews on 8/9/22 and 8/10/22 with client #5 revealed:</p> <ul style="list-style-type: none"> - The clients no longer went to the same restaurant they ate on 4/1/22 "because it is embarrassing." FS #3 "called us retarded and everyone at the restaurant heard it. That's why we don't go there anymore." - While at the restaurant on 4/1/22 FS #3 stated to all the clients, "If you don't shut up I will f**k you up." - She did not know why FS #3 told the clients to "shut up." - "[FS #3] was screaming at everybody at the group home and I don't know why she did that." - "Yes, I was afraid of [FS #3]. I think everyone at the group home was scared of her." - She asked multiple times "Is she coming back?" <p>Interviews on 8/9/22 and 8/10/22 with client #4 revealed:</p> <ul style="list-style-type: none"> - On 4/1/22 she and the other clients were at a restaurant with FS #3. - While at the restaurant, FS #3 said "you b***h" to all of the clients. - She was told by the other clients while she was 	V 512		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL080-164	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 08/18/2022
NAME OF PROVIDER OR SUPPLIER CABARRUS COUNTY GROUP HOME 5		STREET ADDRESS, CITY, STATE, ZIP CODE 106 SOUTH FRANKLIN STREET CHINA GROVE, NC 28023		
(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 21</p> <p>at the cash register paying her food bill, FS #3 called them "retarded."</p> <p>- "I don't want to see [FS #3] ever again because I am scared of her. She cusses us to our face and says ugly words to us. It made me upset and cry in my room all the time."</p> <p>Observation at 10:20 am and Interview on 8/10/22 with client #2 revealed:</p> <p>- Observed client #2 to have limited verbal skills.</p> <p>- "In restaurant [name of restaurant] [FS #3] cussing us."</p> <p>Observation at 11:02 am and interview on 8/10/22 with client #3 revealed:</p> <p>- Observed client #3 to have limited verbal skills.</p> <p>- Did not respond to questions about eating at the restaurant on 4/1/22 but stated "[FS #3] hit [client #5] here." Observed client #3 pointing to his shoulder area at 11:08 am. He was unable to provide any further details about FS #3 hitting client #5.</p> <p>- "Yes" he was afraid of FS #3.</p> <p>Interview on 8/11/22 with staff #2 revealed:</p> <p>- She was not present on 4/1/22 when all the clients and FS #3 had breakfast at the restaurant.</p> <p>- After 4/1/22, client #4 told her she got up to pay for her food and she heard that FS #3 called the clients "stupid and dumb."</p> <p>- Client #1 and client #5 told her that FS #3 called the clients "stupid and dumb."</p> <p>- When she first started working, clients (#1, #4 and #5) had told her FS #3 called them "dumb and retarded."</p> <p>- When she first started working at the group home, FS #3 would leave her notes telling her, "You need to go back to school or learn how to read or something derogatory." She told the administrator about the notes and FS #3 stopped</p>	V 512		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL080-164	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R-C 08/18/2022
NAME OF PROVIDER OR SUPPLIER CABARRUS COUNTY GROUP HOME 5			STREET ADDRESS, CITY, STATE, ZIP CODE 106 SOUTH FRANKLIN STREET CHINA GROVE, NC 28023		
(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 22</p> <p>writing those type of notes to her.</p> <p>- "[FS #3] was a very loud person and she didn't care what she said. She was like a bully, and I was afraid of her."</p> <p>Interview on 8/12/22 with the Administrator revealed:</p> <p>- She received a telephone call from the DPED on 4/1/22 during the morning. The DPED reported to her that a couple (a man and a woman) who were at the restaurant overheard FS #3 talked to the clients "roughly."</p> <p>- She was not in the office on 4/1/22 when the couple had come by, and the couple returned 10 days later.</p> <p>- She was not provided the couple's full names nor their phone numbers when they returned to her office. She could not provide any notes about her conversation with the couple.</p> <p>- The couple told her while at the restaurant on 4/1/22, FS #3 "was loud with them (clients)" and FS #3 told one of the clients to finish her coffee. "He said I am surprised the waitress didn't hear it."</p> <p>- She later talked to the waitress who had "nothing to report." She could not remember the waitress's name.</p> <p>- She talked to FS #3 who reported she told client #5 to "drink her coffee" because she wanted a second cup and they needed to leave to get to the workshop. FS #3 reported to her, that she was on her phone while the clients were sitting at the restaurant table. FS #3 did not report any verbal abuse to her.</p> <p>Interview on 8/11/22 with client #4's legal guardian (LG) revealed:</p> <p>- She talked to her sister (client #4) on 4/1/22 about what occurred at the restaurant earlier that day.</p>	V 512			

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL080-164	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 08/18/2022
NAME OF PROVIDER OR SUPPLIER CABARRUS COUNTY GROUP HOME 5		STREET ADDRESS, CITY, STATE, ZIP CODE 106 SOUTH FRANKLIN STREET CHINA GROVE, NC 28023		
(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 23</p> <ul style="list-style-type: none"> - Client #4 told her all the clients and FS #3 were sitting at the restaurant table together. - Client #4 told her that FS #3 "was talking down to the clients and telling them they were stupid and retarded." - "When I talked to my sister (client #4) they (clients) were pretty upset." - Client #4 had told her, "several times" in the past that FS #3 had yelled and cussed at the clients. She was unsure if it was true or not. <p>Interview on 8/11/22 with client #5's LG revealed:</p> <ul style="list-style-type: none"> - Client #5 had talked to her about the 4/1/22 incident at the restaurant. - Client #5 told her that "[FS #3] yelled at them and slapped them and said f**k you all and called them retarded." - Client #5 does not like FS #3 because FS #3 "makes [client #5] mind." - Client #5 "cannot tell the truth." <p>Interview on 8/11/22 with client #3's LG revealed:</p> <ul style="list-style-type: none"> - Around the time FS #3 was hired, there had been a lot of changes in the group home and she was not sure what to attribute the changes she had noticed with client #3 and the other clients. - When FS #3 started working she had noticed client #3 did not want to return to the group home after his weekend visits. She had also noticed "the group home residents didn't appear to be happy anymore." - Sometime in January or February 2022 she told the administrator she went into the group home and FS #3 was in her bedroom with the door closed. She knocked on FS #3's bedroom door and "she yelled in a rude voice, 'what do you want?' When FS #3 realized it was her, "[FS #3's] voice changed." <p>Interview on 8/15/22 with FS #3 revealed:</p>	V 512		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL080-164	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 08/18/2022
NAME OF PROVIDER OR SUPPLIER CABARRUS COUNTY GROUP HOME 5		STREET ADDRESS, CITY, STATE, ZIP CODE 106 SOUTH FRANKLIN STREET CHINA GROVE, NC 28023		
(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 24</p> <ul style="list-style-type: none"> - She denied all allegations that she called the clients names, cussed, or yelled at the clients while at the restaurant on 4/1/22. - She denied telling any of the clients at the restaurant to finish up their food or they would get a kid's meal next time. - She recalled telling client #5 to finish drinking her coffee. - She resigned on 4/5/22 "because I know I didn't say what I was accused of." <p>Interview on 8/12/22 with the Administrative Assistant revealed:</p> <ul style="list-style-type: none"> - She and the QP interviewed the clients about the 4/1/22 incident. She talked with FS #3 about the 4/1/22 incident. - FS #3 told her that she tried to get client #5 to order a smaller meal while at the restaurant on 4/1/22. FS #3 told her that she told client #5 she should not order a larger meal because she was wasting money. - FS #3 further told her client #5 was "cheeking the food and holding the food in her mouth" while at the restaurant and FS #3 told client #5 to swallow her food. - She felt that the DPED had asked leading questions on 4/1/22 because the clients stated to her, "that is what [DPED] told us." - She indicated that she wrote notes when she interviewed FS #3 and the QP wrote the notes when they interviewed the clients. The administrator would have the notes. <p>Interview on 8/17/22 with the Administrator revealed:</p> <ul style="list-style-type: none"> - She was unable to provide any notes from the interviews with the clients nor FS #3 regarding the 4/1/22 incident. <p>Review on 8/18/22 of the Plan of Protection dated</p>	V 512		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL080-164	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 08/18/2022
NAME OF PROVIDER OR SUPPLIER CABARRUS COUNTY GROUP HOME 5		STREET ADDRESS, CITY, STATE, ZIP CODE 106 SOUTH FRANKLIN STREET CHINA GROVE, NC 28023		
(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 25</p> <p>8/18/22 written by the Qualified Professional #2 and the Administrator revealed:</p> <p>"What immediate action will the facility take to ensure the safety of the consumers in your care? To make sure all residents live in a safe, secure, respectful environment free of abuse, neglect, exploitation and harm (including verbal abuse). To ensure staff are properly trained in what constitutes all types of abuse, neglect, exploitation and harm (especially verbal abuse) To ensure staff appropriately interact with residents.</p> <p>To ensure residents understand what constitutes abuse, neglect, exploitation and harm and how and to whom to report this to if it happens. Describe your plans to make sure the above happens. Staff will be immediately trained by the Qualified Professional (QP) on abuse, neglect, exploitation and harm with an emphasis on what constitutes verbal abuse and bullying by the end of the day on 8/19/22(this training will be done virtually due to current positive COVID cases in the facility)</p> <p>The policy and procedure on abuse, neglect, exploitation and harm has been revised (see copy) to include specifics regarding verbal abuse and bullying and this will also be included in the staff training by the end of the day on 8/19/22. Residents will be informed by the QP of what constitutes abuse, neglect, harm and exploitation (including verbal abuse) and will also be informed by the QP on how to report and who to report to any concerns of abuse, neglect, exploitation and harm (This will be done face to face with all the residents from the facility once the residents are COVID clear)</p> <p>The QP and/or the Administrator will make on-site visits twice a month to the facility(to start once it is COVID clear) to observe staff interaction with clients to ensure interaction is appropriate and</p>	V 512		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL080-164	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 08/18/2022
NAME OF PROVIDER OR SUPPLIER CABARRUS COUNTY GROUP HOME 5		STREET ADDRESS, CITY, STATE, ZIP CODE 106 SOUTH FRANKLIN STREET CHINA GROVE, NC 28023		
(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 26 respectful. (A follow-up face-to face training by the QP with all staff will be done once the facility is COVID clear). Cabarrus County Group Homes, Inc Policy and Procedures Subject: Protections of Clients from Harm Purpose: To Protect Clients from Abuse, Neglect and Exploitation Pursuant to G.S 122C-66 it is the responsibility of all employees to protect all clients from abuse, neglect, exploitation and harm. No form of abuse, neglect or exploitation of clients by employees will be tolerated and such actions by employees will result in immediate dismissal by the Cabarrus County Group Homes. Abuse Physical abuse: physical pain or injury inflicted on a client by an employee which is other than accidental means including any type of corporal punishment; Sexual abuse: any contact of a sexual nature that occurs between a client and an employee including any activity which is meant to arouse or gratify the employee. This can also include any contact of sexual nature between two clients which is not consensual and involved coercion, force or manipulation; Emotional abuse: the mental or emotional injury or distress inflicted on a client by an employee which results in impairment of the client's psychological functioning and affects the client's well-being; Employees will not abuse clients in any way including (but not limited to) the following: Hitting, spanking, shaking, slapping, pushing/shoving, pinching, kicking, rough handling, force feeding Degrading, threatening, cursing, name-calling, shaming, humiliation, cruelty, ridicule, yelling, intimidation, provoking fear of violence, bullying,	V 512		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL080-164	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 08/18/2022
NAME OF PROVIDER OR SUPPLIER CABARRUS COUNTY GROUP HOME 5		STREET ADDRESS, CITY, STATE, ZIP CODE 106 SOUTH FRANKLIN STREET CHINA GROVE, NC 28023		
(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 27 taunting Inappropriate touching, exposing oneself, sexually oriented conversations, sharing sexually oriented pictures/media, sexting Appropriate physical interaction includes: side hugs, pats on shoulder or back, high-fives, fist pumps, shoulder to shoulder hugs, handshakes, arms around shoulders Inappropriate physical interaction includes: full frontal hugs, kisses, showing affection in isolated areas or while one-on-one, lap sitting, wrestling/horseplaying, tickling, massages, touching bottom, chest or genital areas outside of authorized and documented personal care assistance Appropriate verbal interaction includes: positive reinforcement, appropriate jokes, encouragement, praise Inappropriate verbal interaction: name-calling, secrets, cursing, shaming, belittling, derogatory remarks, harsh language, discussing issues of sexual encounters or personal problems/issues with clients Neglect Failure to provide care and/or services by the employee necessary to maintain the mental and/or physical health and well-being of the client; Failure by the employee to protect the client from harm; Employees will not neglect clients in any way including (but not limited to) the following: Failure to provide food, water or clothing Failure to provide prescribed medications Failure to provide appropriate medical care Failure to provide appropriate supervision Exploitation The deliberate manipulation or use of power and control over another person for self-gain The use of a client's person or property for an employee's profit or advantage and the employee	V 512		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL080-164	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 08/18/2022
NAME OF PROVIDER OR SUPPLIER CABARRUS COUNTY GROUP HOME 5		STREET ADDRESS, CITY, STATE, ZIP CODE 106 SOUTH FRANKLIN STREET CHINA GROVE, NC 28023		
(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 28 obtains money, property or services from a client from undue influence, harassment, deception or fraud. Employees will not exploit clients in any way including (but not limited to) the following: Taking the personal property of a client Illegally using money from a client's account Using the client to provide services for the employee's benefit Entering into a business transaction with the client Using deception, coercion and/or manipulation of the client to obtain something for self-gain Employees will be trained on and must adhere to the Code of Ethics and the Statement of Resident Rights. CCGH (Cabarrus County Group Home (Licensee)) has zero tolerance for abuse, mistreatment and bullying among clients within the organization. CCGH is committed to providing all clients with a safe environment and will not tolerate mistreatment or abuse of one client by another client. Interventions are put in place to protect clients from harm by other consumers. Conduct that rises to the level of abuse, mistreatment or bullying will result in interventions and specific strategies to address the issues. Employees will monitor and observe the clients' interactions and will report immediately any incidents of client-on-client abuse, mistreatment and bullying. Such incidents will be investigated and procedures put in place to protect the clients from further abuse, mistreatment or bullying. Each employee is responsible for reporting any instance of abuse, neglect or exploitation of clients whether confirmed or suspected. Any employee who has witnessed or has knowledge of any of the above violations must report such violations in accordance with the CCGH Policies and Procedures. Employees shall report all	V 512		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL080-164	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 08/18/2022
NAME OF PROVIDER OR SUPPLIER CABARRUS COUNTY GROUP HOME 5		STREET ADDRESS, CITY, STATE, ZIP CODE 106 SOUTH FRANKLIN STREET CHINA GROVE, NC 28023		
(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 29</p> <p>accidental injuries to clients witnessed or of which they have knowledge."</p> <p>The group home serves 5 clients with various diagnoses not limited to: Intellectual and Developmental Disabilities; Oppositional Disorder; Autistic Disorder and Depression. While the 5 clients and FS #3 were at a local restaurant on 4/1/22, a couple overheard FS #3 being verbally abusive with the clients. Two of the five clients reported to the group home staff that on 4/1/22, FS #3 yelled, cussed, and called them retarded and other names while at the restaurant. Staff #2 described FS #3 as a bully. The clients were interviewed again four months later and reported that FS #3 cussed, yelled and called them retarded and other names while they were at the restaurant on 4/1/22. Four months later, the clients reported that they were afraid of FS #3.</p> <p>This deficiency constitutes a Type B rule violation which is detrimental to the health, safety and welfare of the clients. If the violation is not corrected within 45 days, an administrative penalty of \$200.00 per day will be imposed for each day the facility is out of compliance beyond the 45th day.</p>	V 512		