Division of Health Service Regulation

| | STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
|--------------------------|---|----------------------|-------------------------|--|-------------------------------|--------------------------|
| | | MHL059-093 | B. WING | | 11/03/2022 | |
| NAME OF F | PROVIDER OR SUPPLIER | STREET AD | | STATE, ZIP CODE | | |
| TAYLOR | 2 HOME | | E STREET T, NC 28762 | ! | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY MUST BE PRECEDED BY FULL | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | D BE | (X5) COMPLETE DATE |
| V 000 | 00 INITIAL COMMENTS | | V 000 | | | |
| | An annual survey was completed on 11/3/22. Deficiencies were cited. | | | | | |
| | This facility is licensed for the following service category: 10A NCAC 27G .5600F Supervised Living for Individuals of all Disability Groups/Alternative Family Living. This facility is licensed for 3 and currently has a census of 3. The survey sample consisted of audits of 3 current clients. | | | | | |
| | | | | | | |
| V 118 | 27G .0209 (C) Med | ication Requirements | V 118 | | | |
| | V 118 27G .0209 (C) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (c) Medication administration: (1) Prescription or non-prescription drugs shall only be administered to a client on the written order of a person authorized by law to prescribe drugs. (2) Medications shall be self-administered by clients only when authorized in writing by the client's physician. (3) Medications, including injections, shall be administered only by licensed persons, or by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer medications. (4) A Medication Administration Record (MAR) of all drugs administered to each client must be kept current. Medications administered shall be recorded immediately after administration. The MAR is to include the following: (A) client's name; (B) name, strength, and quantity of the drug; (C) instructions for administering the drug; (D) date and time the drug is administered; and | | | | | |

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: | | (X2) MULTIPLI A. BUILDING: | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | |
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| | | MHL059-093 | B. WING | | 11/0 | 3/2022 |
| NAME OF | PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, S | TATE, ZIP CODE | | |
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| IAILUK | 2 HOWE | OLD FOR | T, NC 28762 | | | |
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| V 118 | drug. (5) Client requests of the checks shall be recommended in the fille followed up by a with a physician. This Rule is not me | for medication changes or orded and kept with the MAR appointment or consultation | V 118 | | | |
| | facility failed to kee to follow the written clients (Clients #1, and the clients are clients and the clients and the clients are clients and the clients are clients and the clients and the clients are clients are clients are clients. | o the MAR current and failed order of a physician for 3 of 3 #2, #3). The findings are: of Client #1's record revealed: 10/20/21 tellectual Disability, er, Cerebral Palsy, Incontinent, sion, Dysplasia, Reflux (GERD) and Anxiety medications dated 1/27/22 (grams)/15ml (milliliters) 30ml twice daily ordered ed to 45ml twice daily ordered 0ml suspension (antacid)-(gastrostomy tube) twice daily nuscle relaxant)-give 4 times 2.00mg (seizures)-give 3 times | | | | |

Division of Health Service Regulation

STATE FORM 6899 XOW811 If continuation sheet 2 of 14

| Division | of Health Service Re | egulation | | | | |
|--------------------------|--|--|-------------------------------|---|-----------------|--------------------------|
| | NT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLI A. BUILDING: | E CONSTRUCTION | (X3) DATE COMPI | |
| | | MHL059-093 | B. WING | | 11/0 | 3/2022 |
| NAME OF F | PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, S | STATE, ZIP CODE | | |
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| V 118 | Continued From pa | ige 2 | V 118 | | | |
| | ordered 11/18/21Tizanidine 4mg (r tablets 4 times daily -Fluticasone 50mc spray each nostril to -Cetirizine 10mg (6/7/22 -Escitalopram 20n ordered 5/10/22 -Trazodone 150mc bedtime ordered 5/-Senna Plus 8.6-5 ordered 11/24/20Nuedexta 20-10 (ordered 5/10/22Omeprazole 2mg daily ordered 3/7/22 | cg (micrograms) (asthma)- 1 wice daily ordered 4/20/22. callergies)- once daily ordered mg (depression)-once daily g (anti-depressant)-2 tablets at 10/22. 50mg (constipation)- twice daily (anxiety)- give twice daily g/ml (GERD)-give 20ml twice 2. 56 (antifungal)-topical cream | | | | |
| | MARs for Client #1 -Lactulose was not 11/1/22-11/2/22 ampm dosesSucralfate was not 11/1/22-11/2/22 ampm dosesBaclofen was not 11/1/22-11/2/22 8ar 2pm doses, 10/31/2 10/31/22-11/1/22 8pm dosesCoxcarbazepine vadministered on 11/10/31/22-11/1/22 2pm doses. | ot initialed as administered on doses or 10/31/22-11/1/22 not initialed as administered on doses or 10/31/22-11/1/22 of initialed as administered on m doses; 10/31/22-11/1/22 22-11/1/22 4pm doses or | | | | |

Division of Health Service Regulation

11/1/22-11/2/22 8am doses; 10/31/22-11/1/22

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Division of Health Service Regulation

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| | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | |
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| PREFIX | | MUST BE PRECEDED BY FULL | PREFIX | (EACH CORRECTIVE ACTION SHOUL | | COMPLETE |
| TAG | REGULATORY OR L | SC IDENTIFYING INFORMATION) | TAG | CROSS-REFERENCED TO THE APPROF DEFICIENCY) | PRIATE | DATE |
| | | | | DEI ICIENCI) | | |
| V 118 | Continued From pa | ge 3 | V 118 | | | |
| | 2pm doses, or 10/3 | 1/22-11/1/22 8pm doses. | | | | |
| | | not initialed as administered | | | | |
| | on 11/1/22-11/2/22 | am doses or 10/31/22-11/1/22 | | | | |
| | pm doses. | | | | | |
| | | not initialed as administered on | | | | |
| | | n doses; 10/31/22-11/1/22 | | | | |
| | | 22-11/1/22 4pm doses or | | | | |
| | 10/31/22-11/1/22 8p | om doses. s not initialed as administered | | | | |
| | | | | | | |
| | on 11/1/22-11/2/22 am doses or 10/31/22-11/1/22 pm doses. | | | | | |
| | | ot initialed as administered on | | | | |
| | 11/1/22-11/2/22. | | | | | |
| | | as not initialed as administered | | | | |
| | on 11/1/22-11/2/22. | | | | | |
| | -Trazodone was on 10/31/22-11/1/22 | not initialed as administered | | | | |
| | | z. not initialed as administered | | | | |
| | | am doses or 10/31/22-11/1/22 | | | | |
| | pm doses. | um 40303 01 10/01/22 11/1/22 | | | | |
| | • | ot initialed as administered on | | | | |
| | 11/1/22-11/2/22 am | doses or 10/31/22-11/1/22 | | | | |
| | pm doses. | | | | | |
| | -Omeprazole was | not initialed as administered | | | | |
| | | am doses or 10/31/22-11/1/22 | | | | |
| | pm doses. | | | | | |
| | | as not initialed as administered | | | | |
| | on 10/31/22-11/1/22 | 2. | | | | |
| | Review on 11/2/22 | of Client #2's record revealed: | | | | |
| | -Date of Admission: | | | | | |
| | | ittent Explosive Disorder, | | | | |
| | | y, Traumatic Brain Injury, | | | | |
| | | Disorder, Hearing Loss, | | | | |
| | incontinent. | , , | | | | |
| | -Physician ordered | medications dated 1/27/22 | | | | |
| | included: | | | | | |
| | | 37.5mg (depression) once | | | | |
| | daily. | | | | | |
| | -Doxepin 6mg (ar | nxiety) once at bedtime. | | | | |

Division of Health Service Regulation

STATE FORM 6899 XOW811 If continuation sheet 4 of 14

Division of Health Service Regulation

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| | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
| AND FLAN | OF CONNECTION | IDENTIFICATION NOMBER. | A. BUILDING: | | OOM! LETED | |
| | | MHL059-093 | B. WING | | 44/0 | 2/2022 |
| | | | | | 11/0 | 3/2022 |
| NAME OF I | PROVIDER OR SUPPLIER | | | STATE, ZIP CODE | | |
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| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY) | D BE | (X5) COMPLETE DATE |
| V 118 | Continued From pa | ge 4 | V 118 | | | |
| | -Oxcarbazepine 600mg (seizures) 1 ½ tabs twice daily. | | | | | |
| | MARs for Client #2 Was not initialed a PM dose, and 11/1/ -Venlafaxine was on 10/31/22-11/1/22 -Doxepin was not 10/31/22-11/1/22 -Oxcarbazepine wadministered on 11/ 10/31/22-11/1/22 pr Review on 11/2/22 -Date of Admission -Diagnoses: Attenti Disorder (ADHD), In Conduct Disorder, A Hypertension, Atax Intellectual Disabilit | as administered for 10/31/22 22. not initialed as administered 2. initialed as administered on was not initialed as /1/22-11/2/22 am doses or m doses. of Client #3's record revealed: 2/13/21 on Deficit Hyperactivity mpulse Control Disorder, Autism Spectrum Disorder, ia, Hypothyroidism, Moderate y, Sleep Apnea, Epilepsy, | | | | |
| | G-tube fed, MERSA. -Physician ordered medications included: -Risperidone 1mg (antipsychotic) 4 times daily ordered 3/10/22Fluticasone Prop 50mcg (allergies) instill 1 spray both nostrils daily ordered 2/17/21Levothyroxine Sodium 112mg (hypothyroid) once every morning ordered 3/10/22Polyethylene Glycol 3350 (constipation) mix 17grams in water every morning ordered 3/10/22Flintstone's multivitamin with iron (supplement) take daily ordered 4/5/22Memantine 5mg (memory) twice daily ordered 3/10/22Oxcarbazepine 300mg (seizures) take 900mg in AM and 1050mg at bedtime ordered 6/28/22Famotidine 40mg (antacid) take 20mg twice | | | | | |

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Division of Health Service Regulation

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED | | |
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| | | MHL059-093 | B. WING | | 11/03/2022 | |
| NAME OF | PROVIDER OR SUPPLIER | | DRESS CITY S | STATE, ZIP CODE | | 0.2022 |
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| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY) | D BE | (X5) COMPLETE DATE |
| V 118 | Continued From page 5 | | V 118 | | | |
| | daily ordered 4/12/2 -Clonidine 0.1mg (daily ordered 6/17/2 -Baclofen 20mg (rordered 8/9/21Mupirocin 2% top | ng/5ml (pain) take 5ml 3 times 22. (sedative) 1 ½ tablets 3 times | | | | |
| | MARs for Client #3 -Risperidone was on 11/1/22-11/2/22 4pm doses, or 10/3 -Fluticasone was r on 11/1/22-11/2/22 -Levothyroxine So administered on 11/ -Polyethylene Glyc administered on 11/ -Flintstone's multiv initialed as administ -Memantine was r 11/1/22-11/2/22 am pm dosesOxcarbazepine v administered on 11/ 10/31/22-11/1/22 pr -Famotidine was on 11/1/22-11/2/22 4pm doses, or 10/3 -Clonidine was no | not initialed as administered 8am doses; 10/31/22-11/1/22 1/22-11/1/22 8pm doses. not initialed as administered dium was not initialed as 1/1/22-11/2/22. col was not initialed as 1/1/22-11/2/22. vitamin with iron was not tered on 10/31/22-11/1/22. not initialed as administered on doses or 10/31/22-11/1/22 was not initialed as 1/1/22-11/2/22 am doses or | | | | |

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| DIVISION | of Health Service Re | guiation | | | | | |
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| | NT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED | |
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| V 118 | Continued From pa | ige 6 | V 118 | | | | |
| | -Baclofen was not initialed as administered on 11/1/22-11/2/22 am doses or 10/31/22-11/1/22 pm doses. -Mupirocin was not initialed as administered on 11/1/22-11/2/22 am doses or 10/31/22-11/1/22 pm doses. Interview on 11/2/22 with Staff #1 revealed: -Client #1 received his 2pm dose of Baclofen, Oxcarbazepine, Diazepam and Tizanidine from the day program and Client #3 received his 12pm dose of Risperidone and 2pm dose of Baclofen at schoolShe and her husband were moving from the facility on Friday (11/4/22) and had been overwhelmed with packing"Each client absolutely got their medications, I just forgot to document." | | | | | | |
| | | | | | | | |
| | -Staff #1 was movin | 2 with the QP revealed: ng out of town and their last as to be 11/4/22. staff #1 before she works with | | | | | |
| V 131 | G.S. 131E-256 (D2 Verification |) HCPR - Prior Employment | V 131 | | | | |
| | REGISTRY (d2) Before hiring h health care facility of health care facility of Personnel Registry | ealth care personnel into a personnel in | | | | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
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| | | MHL059-093 | B. WING | | 11/03/2022 | |
| NAME OF | PROVIDER OR SUPPLIER | STREET ADI | DRESS, CITY, S | STATE, ZIP CODE | | |
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| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | _D BE | (X5) COMPLETE DATE |
| V 131 | Continued From pa | ge 7 | V 131 | | | |
| V 133 | facility failed to ens substantiated finding on the North Caroli Registry (HCPR) prostaff (Staff #1). The Record review on 1-Date of Hire-9/14/2-Date of HCPR verification of HCPR verification of HCPR verification. They were unsure employee when he Texas. -She was not aware the date of hire. -Will make sure the | view and interviews, the ure each staff member had no ags of abuse or neglect listed na Health Care Personnel for to hire for 1 of 3 audited a findings are | V 133 | | | |
| | G.S. §122C-80 CR CHECK REQUIRE APPLICANTS FOR (a) Definition As a "provider" applies to program and any p developmental disa services that is lice Chapter. (b) Requirement a provider licensed us applicant to fill a po | IMINAL HISTORY RECORD D FOR CERTAIN | | | | |

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| Division | of Health Service Re | egulation | | | | |
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| | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLI A. BUILDING: | E CONSTRUCTION | (X3) DATE COMPI | SURVEY LETED |
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| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | .D BE | (X5) COMPLETE DATE |
| | conditioned on consent to a State and national criminal history record check of the applicant. If the applicant has been a resident of this State for less than five years, then the offer of employment is conditioned on consent to a State and national criminal history record check of the applicant. The national criminal history record check shall include a check of the applicant's fingerprints. If the applicant has been a resident of this State for five years or more, then the offer is conditioned on consent to a State criminal history record check of the applicant. A provider shall not | | V 133 | | | |
| | | | | | | |
| | check of the applicant. A provider shall not employ an applicant who refuses to consent to a criminal history record check required by this section. Except as otherwise provided in this subsection, within five business days of making the conditional offer of employment, a provider | | | | | |
| | Justice under G.S. criminal history reco section or shall sub entity to conduct a s | est to the Department of 114-19.10 to conduct a ord check required by this omit a request to a private State criminal history record his section. Notwithstanding | | | | |
| | G.S. 114-19.10, the return the results of record checks for e covered by Public L Department of Hea | e Department of Justice shall f national criminal history employment positions not Law 105-277 to the lth and Human Services, | | | | |
| | business days of re history of the perso and Human Service | Check Unit. Within five eceipt of the national criminal n, the Department of Health es, Criminal Records Check e provider as to whether the | | | | |
| | information receive of the applicant. In national criminal his with the provider. P | d may affect the employability no case shall the results of the story record check be shared roviders shall make available | | | | |
| | | cation that a criminal history mpleted on any staff covered | | | | |

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| Division | <u>of Health Service Re</u> | egulation | | | | |
|--------------------------|--|--|---|--|-------------------------------|--------------------------|
| | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED | |
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| V 133 | Continued From page 9 | | V 133 | | | |
| | appropriate local or the Division of Crimmay conduct on be criminal history reconsection without the request to the Department of the case, the county should be conditional offer of the conditional of the conditional offer of the conditional of t | n "private entity" means a engaged in conducting ord checks utilizing public om a State agency. Splicant's criminal history also one or more convictions of the provider shall consider allors in determining whether to be eriousness of the crime. Serson at the time of the crime, if known, een the criminal conduct of job duties of the position to be | | | | |

Division of Health Service Regulation STATE FORM

Division of Health Service Regulation

| | or riealth Service IN | | | | | |
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| | IT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | |
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| NAIVIE OF F | PROVIDER OR SUPPLIER | | | STATE, ZIP CODE | | |
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| (X4) ID | | TEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
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| | | | | · · · · · · · · · · · · · · · · · · · | | |
| V 133 | Continued From pa | ge 10 | V 133 | | | |
| | shall not be a bar to | employment; however, the | | | | |
| | | be considered by the provider. | | | | |
| | | ıalifies an applicant after | | | | |
| | | relevant factors, then the | | | | |
| | | se information contained in | | | | |
| | | record check that is relevant | | | | |
| | | on, but may not provide a copy | | | | |
| | | ry record check to the | | | | |
| | applicant. | , | | | | |
| | (d) Limited Immunity A provider and an officer | | | | | |
| | | ovider that, in good faith, | | | | |
| | | ection shall be immune from | | | | |
| | civil liability for: | | | | | |
| | (1) The failure of the | e provider to employ an | | | | |
| | individual on the ba | sis of information provided in | | | | |
| | the criminal history | record check of the individual. | | | | |
| | (2) Failure to check | an employee's history of | | | | |
| | criminal offenses if | the employee's criminal | | | | |
| | history record chec | k is requested and received in | | | | |
| | compliance with this | | | | | |
| | | e As used in this section, | | | | |
| | | neans a county, state, or | | | | |
| | | ory of conviction or pending | | | | |
| | | e, whether a misdemeanor or | | | | |
| | • • | pon an individual's fitness to | | | | |
| | | for the safety and well-being of | | | | |
| | | ental health, developmental | | | | |
| | , | tance abuse services. These | | | | |
| | | criminal offenses set forth in | | | | |
| | | Articles of Chapter 14 of the | | | | |
| | | article 5, Counterfeiting and | | | | |
| | | ubstitutes; Article 5A, | | | | |
| | | itive and Legislative Officers; | | | | |
| | | Article 7A, Rape and Other | | | | |
| | | le 8, Assaults; Article 10, | | | | |
| | | duction; Article 13, Malicious | | | | |
| | | y Use of Explosive or | | | | |
| | | or Material; Article 14, Burglary | | | | |
| | and Other Housebr | eakings; Article 15, Arson and | | | | |

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Division of Health Service Regulation

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` , | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
|---|--|---|---------------------|--|-------------------------------|--------------------------|
| | | MHL059-093 | B. WING | | 11/03/2022 | |
| NAME OF PF | ROVIDER OR SUPPLIER | STREET ADI | DRESS, CITY, S | STATE, ZIP CODE | | |
| TAYLOR 2 | HOME | | E STREET | | | |
| (V4) ID | SLIMMA DV STA | TEMENT OF DEFICIENCIES | T, NC 28762 | PROVIDER'S PLAN OF CORRECTION | - N | (VE) |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY) | D BE | (X5) COMPLETE DATE |
| V 133 | Continued From page 11 | | V 133 | | | |
| | Other Burnings; Art Robbery; Article 18, False Pretenses an Obtaining Property Fraudulent Use of Carticle 19B, Financi Act; Article 20, Frau 26, Offenses Agains Decency; Article 26, Article 27, Prostituti 29, Bribery; Article 35, Office; Article 35, Offenses Agains Office; Article 36A, Article 39, Protection of the Fallotoxication; and Article 39, Protection of the Fallotoxication; and Article 30 of the General Soffenses such as saviolation of G.S. 181 impaired in violation G.S. 20-138.5. (f) Penalty for Furni applicant for employment applicant for employment applicant for employment applicant protection of the Gold Conditional Employment applicant for employmen | icle 16, Larceny; Article 17, Embezzlement; Article 19, d Cheats; Article 19A, or Services by False or Credit Device or Other Means; al Transaction Card Crime Ids; Article 21, Forgery; Article Ist Public Morality and A, Adult Establishments; on; Article 28, Perjury; Article Iffenses Against the Public Iffenses Against the Public Iffenses Against the Public Iticle 60, Computer-Related Iticle | V 133 | | | |

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Division of Health Service Regulation

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | | (X3) DATE SURVEY COMPLETED | | | |
|--|--|--|---|-------------------------|--|-------------------------------|--|--|--|
| | | MHL059-093 | B. WING | | 11/ | 13/2022 | | | |
| MHL059-093 B. WING 11/03/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE | | | | | | | | | |
| TAYLOR 2 HOME 45 MIDDLE STREET OLD FORT, NC 28762 | | | | | | | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | (EACH CORRECTIVE ACTION | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETE DATE | | | | |
| V 133 | fingerprint cards as (2) The provider sh criminal history recebusiness days after conditional employr 2001-155, s. 1; 200 | required in G.S. 114-19.10. all submit the request for a pord check not later than five the individual begins ment. (2000-154, s. 4; 14-124, ss. 10.19D(c), (h); 4, 5(a); 2007-444, s. 3.) | V 133 | | | | | | |
| | interviews, the facil national criminal ba of making the cond | et as evidenced by: el record review and staff ity failed to request a state or eckground check within 5 days itional offer of employment for (Staff #1, #2). The findings | | | | | | | |
| | record revealed: -Hire Date: 9/14/20 -Lived in Texas price being hired by Licel | or to moving to Marion and nsee. nd check ordered on 9/11/20 | | | | | | | |
| | record revealed: -Hire Date: 9/14/20 -Lived in Texas price being hired by Licel | or to moving to Marion and nsee. nd check ordered on 9/11/20 | | | | | | | |
| | revealed: | 2 with the Office Manager ble for completing these hiring | | | | | | | |

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STATE FORM 6899 XOW811 If continuation sheet 13 of 14

Division of Health Service Regulation

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE COMF | (X3) DATE SURVEY COMPLETED | | | | |
|--|---|--|---|-------------------|-------------------------------|--|--|--|--|
| MHL059-093 | | B. WING | | 11/0 | 11/03/2022 | | | | |
| NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE | | | | | | | | | |
| TAYLOR 2 HOME 45 MIDDLE STREET OLD FORT, NC 28762 | | | | | | | | | |
| PREFIX (EACH DEFICIE | STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (X5) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETE DATE | | | | | | |
| was not sufficien | . • | V 133 | | | | | | | |

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