STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL054-184	A. BUILDING: _____ B. WING _____	10/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BARNES GROUP HOMES, LLC 2	2017 EASTRIDGE CIRCLE KINSTON, NC 28504

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V 000	INITIAL COMMENTS A complaint survey was completed on October 11, 2022. The complaint was unsubstantiated (intake #NC00193049). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities. This facility is licensed for 9 and currently has a census of 8. The survey sample consisted of audits of 1 current client.	V 000	This plan of correction is submitted to serve as credible allegation of compliance in association with stated completion dates. Preparation and/or execution of this plan of correction does not constitute an admission or agreement, the provider of conclusion set facts on the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by state and federal law.	
V 132	G.S. 131E-256(G) HCPR-Notification, Allegations, & Protection G.S. §131E-256 HEALTH CARE PERSONNEL REGISTRY (g) Health care facilities shall ensure that the Department is notified of all allegations against health care personnel, including injuries of unknown source, which appear to be related to any act listed in subdivision (a)(1) of this section. (which includes: a. Neglect or abuse of a resident in a healthcare facility or a person to whom home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided. b. Misappropriation of the property of a resident in a health care facility, as defined in subsection (b) of this section including places where home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided. c. Misappropriation of the property of a healthcare facility. d. Diversion of drugs belonging to a health care facility or to a patient or client. e. Fraud against a health care facility or against a patient or client for whom the employee is		Citation # V132 Notification, Allegations, and Protections What measures will be put in place to correct deficiencies? The report of allegations of abuse to the Health Care Personnel Registry had been submitted by October 14, 2022. The facility received an emailed statement on November 9, 2022, stating that the Department has determined that an investigation will not be conducted in this case. What measures will be put in place to prevent the problem from occurring again? On October 14, 2022, Licensee met with QP to discuss the importance of reporting of abuse (neglect, and exploitation) to HCPR at all times. QP will immediately report all allegations to HCPR effective October 14, 2022. Licensee will follow-up with QP within 24hours of becoming aware of the allegation to ensure that all reports of allegations are submitted to HCPR in a timely manner. No Monitoring is necessary.	10/14/2022

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V 132	Continued From page 1 providing services). Facilities must have evidence that all alleged acts are investigated and must make every effort to protect residents from harm while the investigation is in progress. The results of all investigations must be reported to the Department within five working days of the initial notification to the Department. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to report allegations of abuse to the Health Care Personnel Registry (HCPR). The findings are: Review on 10/11/22 of facility records from August 2022 thru October 10, 2022 revealed no allegations of abuse had been reported to the HCPR. Review on 10/11/22 of Former Client (FC) #9's record revealed: -Admission date of 06/11/22. -Diagnoses of Mental Disorder-Due to Brain Damage, Mood Changes, Insomnia, Sexual Abuse as Adult, Blind Right Eye, Dysphoria and Purging.	V 132		

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V 132	Continued From page 2 -Discharge date 09/02/22. Review on 10/11/22 of facility incident reports revealed: 08/11/22 at 6:45pm -FC #9's guardian contacted the administrator on 08/15/22 to report FC #9 stated former staff (FS) #4 slapped her. 08/25/22 -FC #9 accused unknown staff of hitting her. 08/27/22 -Specific time and date of incident unknown. -FC #9's guardian stated she was notified on 08/29/22 that FC #9 made an allegation an unknown staff had slapped her. Interview on 10/11/22 the Licensee stated: -FC #9 had resided in her care for several years. -FC #9 had made allegations of abuse and then recanted her statements. -The facility had not completed HCPR notifications due to FC #9 had changed her stories and denied any abuse. -She understood any allegation of abuse should be reported to the HCPR.	V 132		
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	V 367	V 367 Incident Reporting Requirements What measures will be put in place to correct deficiencies? The Level III incident report of allegations of abuse was submitted in the IRIS by October 14, 2022. What measures will be put in place to prevent the problem from occurring again? On October 14, 2022, Licensee and QP reviewed internal policies & procedures and IRIS manual on what constitutes a Level 1, 2, or 3 as well as when to file an incident. Effective October 14, 2022, QP will submit an IRIS report within 72 hours of becoming aware of the incident. Licensee will follow-up with QP to ensure all known allegations are reported through IRIS in a timely manner (within state guidelines). No monitoring is necessary.	10/14/2022

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V 367	Continued From page 3 90 days prior to the incident to the LME responsible for the catchment area where 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	V 367		

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V 367	Continued From page 4 Substance Abuse Services within 72 hours of becoming aware of the incident. Category A 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). (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: (1) medication errors that do not meet the definition of a level II or level III incident; (2) restrictive interventions that do not meet the definition of a level II or level III incident; (3) searches of a client or his living area; (4) seizures of client property or property in the possession of a client; (5) the total number of level II and level III incidents that occurred; and (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. This Rule is not met as evidenced by:	V 367		

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V 367	Continued From page 5 Based on record reviews and interviews the facility failed to complete a Level II incident report. The findings are: Review on 10/11/22 of the North Carolina Incident Response Improvement System (IRIS) revealed no Level III incident reports completed frm August 2022 thru October 11, 2022. Review on 10/11/22 of Former Client (FC) #9's record revealed: -Admission date of 06/11/22. -Diagnoses of Mental Disorder-Due to Brain Damage, Mood Changes, Insomnia, Sexual Abuse as Adult, Blind Right Eye, Dysphoria and Purging. -Discharge date 09/02/22. Review on 10/11/22 of facility incident reports revealed: 08/11/22 at 6:45pm -FC #9's guardian contacted the administrator on 08/15/22 to report FC #9 stated former staff (FS) #4 slapped her. 08/25/22 -FC #9 accused unknown staff of hitting her. 08/27/22 -Specific time and date of incident unknown. -FC #9's guardian stated she was notified on 08/29/22 that FC #9 made an allegation an unknown staff had slapped her. Interview on 10/11/22 the Licensee stated: -FC #9 had resided in her care for several years. -FC #9 had made allegations of abuse and then recanted her statements. -The facility had not completed IRIS reports due to FC #9 had changed her stories and denied any	V 367		

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V 367	Continued From page 6 abuse. -She understood any allegation of abuse should be reported in the IRIS system.	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 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	V 500		

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V 500	Continued From page 7 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 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 reviews and interviews the facility failed to report to the Department of Social Services (DSS) in the county where services are provided all allegations of resident abuse by health care personnel. The findings are: Review on 10/11/22 of facility records from August 2022 thru October 11, 2022 revealed no reports of allegations of abuse to the local DSS.	V 500		

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V 500	Continued From page 8 Review on 10/11/22 of Former Client (FC) #9's record revealed: -Admission date of 06/11/22. -Diagnoses of Mental Disorder-Due to Brain Damage, Mood Changes, Insomnia, Sexual Abuse as Adult, Blind Right Eye, Dysphoria and Purging. -Discharge date 09/02/22. Review on 10/11/22 of facility incident reports revealed: 08/11/22 at 6:45pm -FC #9's guardian contacted the administrator on 08/15/22 to report FC #9 stated former staff (FS) #4 slapped her. 08/25/22 -FC #9 accused unknown staff of hitting her. 08/27/22 -Specific time and date of incident unknown. -FC #9's guardian stated she was notified on 08/29/22 that FC #9 made an allegation an unknown staff had slapped her. Interview on 10/11/22 the Licensee stated: -FC #9 had resided in her care for several years. -FC #9 had made allegations of abuse and then recanted her statements. -The facility had not notified the local DSS due to FC #9 had changed her stories and denied any abuse. -She understood any allegation of abuse should be reported DSS.	V 500	V 500 Policy of Rights What measures will be put in place to correct deficiencies? The local DSS has been notified by October 14, 2022; on the subject pertaining to the allegation of resident abuse by health care personnel. The Level III incident report of allegations of abuse was submitted in the IRIS by October 14, 2022. What measures will be put in place to prevent the problem from occurring again? On October 14, 2022, Licensee and QP reviewed internal policies & procedures and when to file a report with the local DSS on all allegations of abuse (neglect, and exploitation). Effective October 14, 2022, QP will report all known allegations to the local DSS with a timely manner (within state reporting guidelines). Licensee will follow-up with QP to ensure all known allegations are reported to local DSS in a timely manner.	10/14/2022

NC DEPARTMENT OF
HEALTH AND
HUMAN SERVICES

ROY COOPER • Governor
KODY H. KINSLEY • Secretary
MARK PAYNE • Director, Division of Health Service Regulation

November 9, 2022

Carrie Dudley, Director
Barnes Group Homes, LLC
P.O. Box 2503
Kinston, NC 28502

Re: Complaint Survey completed October 11, 2022
Barnes Group Home, LLC 2, 2017 Eastridge Circle, Kinston, NC 28501
MHL # 054-184
E-mail Address: carrieblessed@yahoo.com
Intake #NC00193049

Dear Ms. Dudley:

Thank you for the cooperation and courtesy extended during the complaint survey completed October 11, 2022. The complaint was unsubstantiated.

Enclosed you will find all deficiencies cited listed on the Statement of Deficiencies Form. The purpose of the Statement of Deficiencies is to provide you with specific details of the practice that does not comply with state regulations. You must develop one Plan of Correction that addresses each deficiency listed on the State Form and return it to our office within ten days of receipt of this letter. Below you will find details of the type of deficiencies found, the time frames for compliance plus what to include in the Plan of Correction.

Type of Deficiencies Found

- All tags cited are standard level deficiencies.

Time Frames for Compliance

- Standard level deficiencies must be ***corrected*** within 60 days from the exit of the survey, which is December 10, 2022.

What to include in the Plan of Correction

- Indicate what measures will be put in place to ***correct*** the deficient area of practice (i.e. changes in policy and procedure, staff training, changes in staffing patterns, etc.).
- Indicate what measures will be put in place to ***prevent*** the problem from occurring again.
- Indicate ***who will monitor*** the situation to ensure it will not occur again.
- Indicate ***how often*** the monitoring will take place.
- Sign and date the bottom of the first page of the State Form.

Make a copy of the Statement of Deficiencies with the Plan of Correction to retain for your records. ***Please do not include confidential information in your plan of correction and please remember never to send confidential information (protected health information) via email.***

Send the original completed form to our office at the following address within 10 days of receipt of this letter.

Mental Health Licensure and Certification Section
NC Division of Health Service Regulation
2718 Mail Service Center
Raleigh, NC 27699-2718

A follow up visit will be conducted to verify all violations have been corrected. If we can be of further assistance, please call Gloria Locklear, Team Leader at (910)214-0350.

Sincerely,

Keith Hughes
Facility Compliance Consultant I
Mental Health Licensure & Certification Section

Cc: DHSRreports@eastpointe.net
Pam Pridgen, Administrative Supervisor