STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		IDENTIFIC/THOM NOMBER.	A. BUILDING:				
		MHL026-643	B. WING			C 03/17/2023	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE			
CRES	GROUP HOME #5		NCE CHARLES EVILLE, NC 28				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE	
V 000	INITIAL COMMENT	S	V 000				
	A complaint survey was completed on March 17, 2023. The complaint was substantiated (intake #NC00199157). Deficiencies were cited.						
	This facility is licensed for the following service category: 10A NCAC 27G .5600 C Supervised Living for Adults with Developmental Disabilities.						
		eed for 6 and currently has a rvey sample consisted of clients.					
V 110	27G .0204 Training Paraprofessionals	/Supervision	V 110				
	SUPERVISION OF (a) There shall be a paraprofessionals. (b) Paraprofession associate profession professional as spe Subchapter. (c) Paraprofessional knowledge, skills ar population served. (d) At such time as	04 COMPETENCIES AND PARAPROFESSIONALS no privileging requirements for als shall be supervised by an nal or by a qualified cified in Rule .0104 of this als shall demonstrate ad abilities required by the a competency-based in is established by rulemaking					
	then qualified profe professionals shall (e) Competence sh exhibiting core skills (1) technical knowl	ssionals and associate demonstrate competence. nall be demonstrated by s including: edge;	,				
	<ul> <li>(2) cultural awaren</li> <li>(3) analytical skills;</li> <li>(4) decision-makin</li> <li>(5) interpersonal sl</li> <li>(6) communication</li> <li>(7) clinical skills.</li> </ul>	g; kills;					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			
		MHL026-643	B. WING			C 17/2023
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
CRES	T GROUP HOME #5					
			EVILLE, NC 28		CORRECTION	()(5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
V 110	Continued From page 1		V 110			
	develop and implen for the initiation of t	body for each facility shall nent policies and procedures he individualized supervision ch paraprofessional.				
	failed to ensure sta skills and abilities re served affecting 1 c Home Manager (Gl	view and interview, the facility ff demonstrated knowledge, equired by the population of 1 audited former Group HM). The findings are: of the former GHM's record				
	-68 year old male. -Admitted on 7/13/9 -Diagnoses of Mode					
	a little while. -He had all new sta	n) was going to get him out in				
	guardian stated:	3 and 3/17/23 client #1's ner GHM was there any ing client #1.				

STATE FORM

09GV11

STATEMENT OF DEFICIENCIES(X1) PROVIDER/SUPPLIER/CLIAAND PLAN OF CORRECTIONIDENTIFICATION NUMBER:				CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			A. BUILDING:				
		MHL026-643	B. WING			C 03/17/2023	
IAME OF F	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, ST	TATE, ZIP CODE			
REST	GROUP HOME #5	250 PRIN	ICE CHARLES	DRIVE			
		FAYETTE	VILLE, NC 28	3311			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE	
V 110	Continued From page	ge 2	V 110				
		tated he knew of someone if					
	she wanted to talk t	ermission to the former GHM					
		ient #1 up on the weekend.					
	Interview on 3/17/23 the Former GHM stated:						
	-He worked at the facility as the GHM for 10 - 12 years.						
	-He was approached by administration who						
	stated he requested several meetings with client						
	families stating he was leaving the facility.						
	-He was asked by client #1's guardian about any						
	other providers. -Client #1 was familiar with a former staff (FS)						
	who was an Alterna	tive Family Living (AFL)					
		S weekly during special					
	Olympic bowling.	nt #1 continued to text her and					
		S contact client #1's guardian.					
	-Client #1's guardia						
	co-guardian/brother						
		guardian's and the FS to meet					
	the with client #1 at						
		FS contact the Local to see what was best for					
	client #1.						
	-The FS picked up of	client #1 once or twice					
	monthly.						
		S contact the guardian's I to pick up client #1.					
		ne visits were documented.					
		act the staff on duty to					
	arrange pick up.	<b>y</b>					
	-He was unsure if the	ne Director had knowledge of					
	the FS picking up cl	lient #1 for visits.					
	Interview on 3/10/23	3 the Executive					
	Director/Qualified P						
	-The former GHM a	rranged meetings with some					

Division of Health STATE FORM

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL026-643	B. WING	B. WING		C 17/2023
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	ATE, ZIP CODE		
CRES	T GROUP HOME #5		ICE CHARLES EVILLE, NC 28			
(X4) ID			ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE
V 110	Continued From pa	ge 3	V 110			
V 110 V 738	Continued From page 3 of the client family members and another FS to discuss the option of moving clients to a new home. -Client #1's co-guardian/brother stated he was contacted by the FS and a meeting was held. -The guardian's had not called him because they believe the former GHM was acting on CREST's behalf. -He believed the guardian's gave permission to the former GHM for the FS to pick up client #1. -He was unsure if client #1 continued to visit with the FS. -No other staff had reported client #1 going with the FS. -The former GHM was terminated. 27G .0303(d) Pest Control 10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS (d) Buildings shall be kept free from insects and rodents.		V 738			
	failed to keep the fa findings are: Review on 3/17/23 of inspection report re -Work Date 2/24/23 -Service Description ONLY"	view and interviews the facility icility free of insects. The of a local pest control vealed: n "BED BUG INSPECTION s/Instructions "Inspection only				

If continuation sheet 4 of 5

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
AND FLAN OF CONNECTION		IDENTIFICATION NOMBER.		A. BUILDING:			
		MHL026-643	B. WING			C 03/17/2023	
AME OF F	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE			
REST	GROUP HOME #5		ICE CHARLES				
			EVILLE, NC 28				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE	
V 738	Continued From pa	ge 4	V 738				
	Interview on 3/17/23 technician stated: -He completed an in -There was bed bug Interview on 3/17/23 stated: -There was a current the home. -She was informed month ago. -Client #2 found bea -A staff told her clie room. -The facility had a h -They had two sepa treat the facility. -One of the compar inspection and the of scheduled. Interview on 3/10/23 Director/Qualified P -There was evident	<ul> <li>Ibugs in his room.</li> <li>acility recently for bed bugs.</li> <li>3 a local pest control</li> <li>nspection on 2/24/23.</li> <li>g activity in 2 bedrooms.</li> <li>3 the Executive Assistant</li> <li>at infestation of bed bugs at</li> <li>of the bed bugs about a</li> <li>d bugs in his room.</li> <li>nt #1 also had bed bugs in his</li> <li>nistory of bed bugs.</li> <li>arate companies they used to</li> <li>nies had completed an</li> <li>other company was</li> <li>3 the Executive</li> </ul>					

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