| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | MHL049-079 | A. BUILDING: _____ B. WING _____ | R 07/05/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WEAVER | 203 NORTH TORIA DRIVE STATESVILLE, NC 28625 |

| (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 | INITIAL COMMENTS<br><br>An annual and follow up survey was completed on7/5/23. Deficiencies were cited.<br><br>This facility is licensed for the following service categories: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities and 10A NCAC 27G .5100 Community Respite Services for Individuals of all Disability Groups.<br><br>This facility is licensed for 4 and currently has a census of 4. The survey sample consisted of audits of 3 current clients. | V 000 | | |
| V 112 | 27G .0205 (C-D)<br>Assessment/Treatment/Habilitation Plan<br><br>10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN<br>(c) The plan shall be developed based on the assessment, and in partnership with the client or legally responsible person or both, within 30 days of admission for clients who are expected to receive services beyond 30 days.<br>(d) The plan shall include:<br>(1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement;<br>(2) strategies;<br>(3) staff responsible;<br>(4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both;<br>(5) basis for evaluation or assessment of outcome achievement; and<br>(6) written consent or agreement by the client or responsible party, or a written statement by the provider stating why such consent could not be obtained. | V 112 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | MHL049-079 | A. BUILDING: _____ B. WING _____ | R 07/05/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WEAVER | 203 NORTH TORIA DRIVE STATESVILLE, NC 28625 |

| (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 112 | Continued From page 1 | V 112 | | |

This Rule is not met as evidenced by:
Based on record reviews and interview, the facility failed to review the treatment plan at least annually for 1 of 3 audited clients (#1) The findings are:

Review on 6/30/23 of client #1's record revealed:
-Date of admission: 12/16/18
-Diagnoses: Mild Intellectual Developmental Disability and Major Depressive Disorder
-No documentation that the treatment plan had been updated since 1/31/22.

Review on 7/5/23 of an email from the Director of Quality Management and Training revealed:
- She was unable to provide an updated copy of client #1's treatment plan.

Interview on 7/5/23 with the House Manager revealed:
- Client #1's treatment plan expired 1/30/23.
- Client #1's treatment plan "needs to be updated."
- "I have told the QP (Qualified Professional) that [client #1's] ISP (Individual Support Plan) is not up to date, and she (QP) said it was on her to do list."

This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | MHL049-079 | A. BUILDING: _____ B. WING _____ | R 07/05/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WEAVER | 203 NORTH TORIA DRIVE STATESVILLE, NC 28625 |

| (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 131 | G.S. 131E-256 (D2) HCPR - Prior Employment Verification<br><br>G.S. §131E-256 HEALTH CARE PERSONNEL REGISTRY<br>(d2) Before hiring health care personnel into a health care facility or service, every employer at a health care facility shall access the Health Care Personnel Registry and shall note each incident of access in the appropriate business files.<br><br>This Rule is not met as evidenced by:<br>Based on record reviews, and interview, the facility failed to access the Health Care Personnel Registry (HCPR) prior to hire for staff #1 and the Qualified Professional (QP). The findings are:<br><br>Review on 7/5/23 of Staff #1's employee file revealed:<br>- Hire date: 10/12/21<br>- The HCPR was not accessed until 7/5/23.<br><br>Review on 7/5/23 of the QP's employee file revealed:<br>- Hire date: 5/2/23<br>- The HCPR was not accessed until 7/5/23.<br><br>Interview on 7/5/23 with the Human Resource Director revealed:<br>- She did not see a HCPR check in client #1's file nor the QP's file.<br>- It was the responsibility of the Human Resource Director to complete the HCPR checks for new employees. | V 131 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | MHL049-079 | A. BUILDING: _____ B. WING _____ | R 07/05/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WEAVER | 203 NORTH TORIA DRIVE STATESVILLE, NC 28625 |

| (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 131 | Continued From page 3<br>- She was not the Human Resource Director when staff #1 and the QP were hired. | V 131 | | |
| V 536 | 27E .0107 Client Rights - Training on Alt to Rest. Int.<br><br>10A NCAC 27E .0107 TRAINING ON ALTERNATIVES TO RESTRICTIVE INTERVENTIONS<br>(a) Facilities shall implement policies and practices that emphasize the use of alternatives to restrictive interventions.<br>(b) Prior to providing services to people with disabilities, staff including service providers, employees, students or volunteers, shall demonstrate competence by successfully completing training in communication skills and other strategies for creating an environment in which the likelihood of imminent danger of abuse or injury to a person with disabilities or others or property damage is prevented.<br>(c) Provider agencies shall establish training based on state competencies, monitor for internal compliance and demonstrate they acted on data gathered.<br>(d) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course.<br>(e) Formal refresher training must be completed by each service provider periodically (minimum annually).<br>(f) Content of the training that the service provider wishes to employ must be approved by the Division of MH/DD/SAS pursuant to Paragraph (g) of this Rule.<br>(g) Staff shall demonstrate competence in the | V 536 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | MHL049-079 | A. BUILDING: _____ B. WING _____ | R 07/05/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WEAVER | 203 NORTH TORIA DRIVE STATESVILLE, NC 28625 |

| (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 536 | Continued From page 4<br>following core areas:<br>(1) knowledge and understanding of the people being served;<br>(2) recognizing and interpreting human behavior;<br>(3) recognizing the effect of internal and external stressors that may affect people with disabilities;<br>(4) strategies for building positive relationships with persons with disabilities;<br>(5) recognizing cultural, environmental and organizational factors that may affect people with disabilities;<br>(6) recognizing the importance of and assisting in the person's involvement in making decisions about their life;<br>(7) skills in assessing individual risk for escalating behavior;<br>(8) communication strategies for defusing and de-escalating potentially dangerous behavior; and<br>(9) positive behavioral supports (providing means for people with disabilities to choose activities which directly oppose or replace behaviors which are unsafe).<br>(h) Service providers shall maintain documentation of initial and refresher training for at least three years.<br>(1) Documentation shall include:<br>(A) who participated in the training and the outcomes (pass/fail);<br>(B) when and where they attended; and<br>(C) instructor's name;<br>(2) The Division of MH/DD/SAS may review/request this documentation at any time.<br>(i) Instructor Qualifications and Training Requirements:<br>(1) Trainers shall demonstrate competence by scoring 100% on testing in a training program | V 536 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | MHL049-079 | A. BUILDING: _____ B. WING _____ | R 07/05/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WEAVER | 203 NORTH TORIA DRIVE STATESVILLE, NC 28625 |

| (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 536 | Continued From page 5 | V 536 | | |

aimed at preventing, reducing and eliminating the need for restrictive interventions.
(2) Trainers shall demonstrate competence by scoring a passing grade on testing in an instructor training program.
(3) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course.
(4) The content of the instructor training the service provider plans to employ shall be approved by the Division of MH/DD/SAS pursuant to Subparagraph (i)(5) of this Rule.
(5) Acceptable instructor training programs shall include but are not limited to presentation of:
(A) understanding the adult learner;
(B) methods for teaching content of the course;
(C) methods for evaluating trainee performance; and
(D) documentation procedures.
(6) Trainers shall have coached experience teaching a training program aimed at preventing, reducing and eliminating the need for restrictive interventions at least one time, with positive review by the coach.
(7) Trainers shall teach a training program aimed at preventing, reducing and eliminating the need for restrictive interventions at least once annually.
(8) Trainers shall complete a refresher instructor training at least every two years.
(j) Service providers shall maintain documentation of initial and refresher instructor training for at least three years.
(1) Documentation shall include:
(A) who participated in the training and the

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | MHL049-079 | A. BUILDING: _____ B. WING _____ | R 07/05/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WEAVER | 203 NORTH TORIA DRIVE STATESVILLE, NC 28625 |

| (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 536 | Continued From page 6<br>outcomes (pass/fail);<br>(B) when and where attended; and<br>(C) instructor's name.<br>(2) The Division of MH/DD/SAS may request and review this documentation any time.<br>(k) Qualifications of Coaches:<br>(1) Coaches shall meet all preparation requirements as a trainer.<br>(2) Coaches shall teach at least three times the course which is being coached.<br>(3) Coaches shall demonstrate competence by completion of coaching or train-the-trainer instruction.<br>(l) Documentation shall be the same preparation as for trainers.<br><br>This Rule is not met as evidenced by:<br>Based on records review and interviews, the facility failed to have training updated annually in alternatives to restrictive interventions for 1 of 2 audited staff (#1). The findings are:<br><br>Review on 7/5/23 of staff #1's record revealed:<br>- Hire date: 10/12/21<br>- A job description of Direct Support Professional<br>- An expired certificate for North Carolina Intervention (NCI) training Part A<br><br>Interview on 7/5/23 with staff #1 revealed:<br>- The last time she had NCI training Part A was in 2021. | V 536 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | MHL049-079 | A. BUILDING: _____ B. WING _____ | R 07/05/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WEAVER | 203 NORTH TORIA DRIVE STATESVILLE, NC 28625 |

| (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 536 | Continued From page 7<br>Interview on 7/5/23 with the Human Resource Director revealed:<br>- It was the House Manager's responsibility for making sure the staff completed NCI training. | V 536 | | |
| V 736 | 27G .0303(c) Facility and Grounds Maintenance<br><br>10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS<br>(c) Each facility and its grounds shall be maintained in a safe, clean, attractive and orderly manner and shall be kept free from offensive odor.<br><br>This Rule is not met as evidenced by:<br>Based on interview and observation, the facility was not maintained in a safe, clean, attractive, and orderly manner. The findings are:<br><br>Observation on 7/5/23 at approximately 2:42 pm of client #4's closet revealed:<br>- Client #4's closet had double doors. The door on the right side was missing and the door on the left side had a hole at the top.<br><br>Interview on 7/5/23 with the House Manager revealed:<br>- She had sent two orders to the maintenance staff on 3/8/23 and 5/31/23. She requested that client #4's closet doors be replaced and repaired.<br>- "It has still not been done." | V 736 | | |