PRINTED: 07/24/2023 FORM APPROVED

Division of Health Service Regulation

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:                            |                     |   |  | ) DATE SURVEY<br>COMPLETED |  |
|--|--|---|---------------------|---|--|----------------------------|--|
| AND I LAN OF CONNECTION                          |  |   | A. BUILDING:        |   |  |                            |  |
|  | MHL055093 B. WING  |   |                     | 07/13/2023  |  |                            |  |
| NAME OF P  | ROVIDER OR SUPPLIER  | STREET ADD  | RESS, CITY, STA     | TE, ZIP CODE  |  |                            |  |
| PATRIOT  | LANE   |   | RGETOWN RO          |   |  |                            |  |
|  |  |   | ON, NC 28092        |   |  |                            |  |
| (X4) ID<br>PREFIX<br>TAG                         | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   |   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE   |  |
| V 000  | INITIAL COMMENTS   |   | V 000               |   |  |                            |  |
|  | An annual survey was completed on July 13, 2023. Deficiencies were cited.  |   |                     |   |  |                            |  |
|  | This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disability.  |   |                     |   |  |                            |  |
|  |  | d for 3 and currently has a vey sample consisted of ents.                     |                     |   |  |                            |  |
| V 108  | 27G .0202 (F-I) Personnel Requirements   |   | V 108               |   |  |                            |  |
|  | 10A NCAC 27G .0202 PERSONNEL REQUIREMENTS (f) Continuing education shall be documented. (g) Employee training programs shall be provided and, at a minimum, shall consist of the following: (1) general organizational orientation; (2) training on client rights and confidentiality as delineated in 10A NCAC 27C, 27D, 27E, 27F and 10A NCAC 26B; (3) training to meet the mh/dd/sa needs of the client as specified in the treatment/habilitation plan; and (4) training in infectious diseases and bloodborne pathogens. (h) Except as permitted under 10a NCAC 27G .5602(b) of this Subchapter, at least one staff member shall be available in the facility at all times when a client is present. That staff member shall be trained in basic first aid including seizure management, currently trained to provide cardiopulmonary resuscitation and trained in the Heimlich maneuver or other first aid |   |                     |   |  |                            |  |
|  | the American Heart A   | nose provided by Red Cross,<br>ssociation or their<br>ing airway obstruction. |                     |   |  |                            |  |

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

Division of Health Service Regulation

| STATEMENT OF DEFICIENCIES |  | (X1) PROVIDER/SUPPLIER/CLIA   | (X2) MULTIPLE CONSTRUCTION |  | (X3) DATE SURVEY                                |   |
|---------------------------|--|---|----------------------------|--|---|---|
| AND PLAN OF CORRECTION    |  | IDENTIFICATION NUMBER:  | A. BUILDING:               |  | COMPLETED                                       |   |
|                           |  |   |                            |  |   |   |
|                           | MHL055093  |   | B. WING                    |  | 07/13/2023                                      |   |
| NAME OF P                 | ROVIDER OR SUPPLIER  | STREET ADD  | RESS, CITY, STA            | TE, ZIP CODE   |   |   |
|                           |  | 1252 GEOF   | RGETOWN RO                 | AD   |   |   |
| PATRIOT                   | LANE   | LINCOLNT  | ON, NC 28092               | 2  |   |   |
| (X4) ID                   | SUMMARY ST   | ATEMENT OF DEFICIENCIES   | ID                         | PROVIDER'S PLAN OF CORRECTION  | I (X5)  | - |
| PREFIX<br>TAG             | (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   |   | PREFIX<br>TAG              | (EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPF<br>DEFICIENCY) | CTION SHOULD BE COMPLETE O THE APPROPRIATE DATE |   |
| V 108                     | Continued From page 1  |   | V 108                      |  |   |   |
|                           | (i) The governing boo<br>implement policies ar<br>reporting, investigatin  |   |                            |  |   |   |
|                           | failed to ensure at leat the facility who was tr Cardiopulmonary Res of 3 audited staff (State Review on 7/11/23 of -Hired 4/6/20; -Employed as a Direct control of the failed to ensure a state of the failed to ensure at least the failed to ensure at least the failed to ensure a state of the failed to ensure a state o | ew and interview, the facility ast one staff was available in rained in First Aid and suscitation (CPR) affecting 1 (ff #2). The findings are:  Staff #2's record revealed: |                            |  |   |   |
|                           | CPR.   | f training in First Aid and   |                            |  |   |   |
|                           | Interview on 7/12/23 v<br>-Worked second shift   | mentation of completing   |                            |  |   |   |
|                           | CPR training for Staff   | with the Administrator nentation of First Aid and f #2, but believed he had the   |                            |  |   |   |
|                           | training.  |   |                            |  |   |   |
| V 131                     | G.S. 131E-256 (D2) H<br>Verification   | HCPR - Prior Employment   | V 131                      |  |   |   |
|                           | G.S. §131E-256 HEA   | LTH CARE PERSONNEL  |                            |  |   |   |

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                        |  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                     |   | (X3) DATE SURV<br>COMPLETED |                          |  |
|--|--|---|---------------------|---|-----------------------------|--------------------------|--|
| MHL055093  |  | B. WING   |                     | 07/13/2   | 07/13/2023                  |                          |  |
| NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS,  1252 GEORGETO LINCOLNTON, N |  |   |                     |   |                             |                          |  |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROFIDEFICIENCY) | O BE C                      | (X5)<br>COMPLETE<br>DATE |  |
| V 131  | REGISTRY (d2) Before hiring health care facility or health care facility shapersonnel Registry at of access in the approximately approximately access to the | alth care personnel into a<br>service, every employer at a<br>all access the Health Care<br>nd shall note each incident<br>opriate business files.  | V 131               |   |                             |                          |  |
|  | failed to access the H<br>Registry and docume<br>offer of employment a<br>(Staff #2). The finding<br>Review on 7/11/23 of<br>-Hired 4/6/20;  | ealth Care Personnel nt the findings prior to an affecting 1 of 3 audited staff gs are: Staff #2's record revealed: at Support Professional; 80/20. |                     |   |                             |                          |  |
|  | revealed: -Did not know why the completed late; -The HCPR review was to hire.  | e HCPR review was   |                     |   |                             |                          |  |

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