Division of Health Service Regulation

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SUR' AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A PUBLIC.					
7 IND 1 EATH	OF CONTRECTION	DENTI TO ATTENTION DETA	A. BUILDING:			
		MHL033-052	B. WING		10/0	2/2023
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
SOMEON	NE DOES CARE	601 WEST	WALNUT S	TREET		
SOMEON	NE DOES CARE	TARBORO	), NC 27886			
(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
∨ 000	INITIAL COMMENT	rs	∨ 000			
	completed on Octol	nt and follow up survey was per 2, 2023. The complaint d (Intake #NC00207061). ited.				
	category: 10A NCA	sed for the following service C 27G .5600C Supervised h Developmental Disability.				
		sed for 6 and currently has a rvey sample consisted of clients.				
		Deficiency was amended on to include all deficiencies wey exit.				
V 133	G.S. 122C-80 Crim	inal History Record Check	V 133			
	CHECK REQUIRED APPLICANTS FOR (a) Definition As a "provider" applies to program and any properties that is licer chapter. (b) Requirement A provider licensed un applicant to fill a po applicant to have an conditioned on cons	EMPLOYMENT.  used in this section, the term of an area authority/county ovider of mental health, bility, and substance abuse ensable under Article 2 of this  An offer of employment by a ender this Chapter to an esition that does not require the en occupational license is esent to a State and national				
	the applicant has be less than five years is conditioned on co	ord check of the applicant. If een a resident of this State for then the offer of employment onsent to a State and national ord check of the applicant. The				
	national criminal his	story record check shall				
Division of H	ealth Service Regulation					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Doris Sessoms, Adminstrator, 11/13/2023

STATE FORM

6899 FN8R11 If con inua ion sheet 1 of 15

ivision of Health Service	Regulation			
TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL033-052	B. WING		R 10/02/2023
AME OF PROVIDER OR SUPPLIE	R STREET AD	DRESS CITY S	STATE, ZIP CODE	
		Γ WALNUT S		
OMEONE DOES CARE	TARBOR	D, NC 27886	3	
PREFIX (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE
the applicant has five years or more on consent to a Scheck of the application application. Except a subsection. Except a subsection, within the conditional of shall submit a reduction or shall submit a reduction or shall sentity to conduct check required by G.S. 114-19.10, the return the results record checks for covered by Public Department of He Criminal Records business days of history of the persand Human Servi Unit, shall notify the information received the applicant. In national criminal with the provider, upon request vericheck has been on by this section. A appropriate local the Division of Criminal history received to the conduct on the criminal history received the section of Criminal history received the section	f the applicant's fingerprints. If been a resident of this State for e, then the offer is conditioned tate criminal history record cant. A provider shall not ant who refuses to consent to a cord check required by this is otherwise provided in this if five business days of making fer of employment, a provider quest to the Department of 5. 114-19.10 to conduct a cord check required by this abmit a request to a private a State criminal history record of this section. Notwithstanding the Department of Justice shall of national criminal history employment positions not a Law 105-277 to the ealth and Human Services, Check Unit. Within five receipt of the national criminal son, the Department of Health ces, Criminal Records Check the provider as to whether the red may affect the employability in no case shall the results of the nistory record check be shared Providers shall make available fication that a criminal history ompleted on any staff covered county that has adopted an ordinance and has access to minal Information data bank wehalf of a provider a State cord check required by this e provider having to submit a	V 133	To address this concern, the will conduct background che to scheduling the potential stor an interview. Continue to complete criminal checks, the QP, will ensure these checks are before any offer for employing and/or and interview is cond. This will take place immediated QP's will monitor this issue in All current staff member have criminal checks. All staff chatalogists. All staff chatalogists.	ecks prior taff member will a background or completed nent is made ucted. tely. monthly.

Division of Health Service Regulation

STATE FORM 6899 If con inua ion sheet 2 of 15 FN8R11

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION	(1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE :	
AND TEAN OF CONNECTION	IDENTIFICATION NUMBER.	A. BUILDING:		OOMI I	LETED
	MHL033-052	B. WING		10/0	2/2023
NAME OF PROVIDER OR SUPPLIER	STREET ADD	ORESS, CITY, S	STATE, ZIP CODE		
COMPONE DOES CARE	601 WEST	WALNUT S	TREET		
SOMEONE DOES CARE	TARBORO	, NC 27886			
PREFIX (EACH DEFICIENCY MU	MENT OF DEFICIENCIES UST BE PRECEDED BY FULL IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
criminal history record section within five bus conditional offer of em All criminal history information provider is confidential except to the applicant (c) of this section. For subsection, the term business regularly endering criminal history record records obtained from (c) Action If an applimate record check reveals of a relevant offense, the of the following factors hire the applicant:  (1) The level and serion (2) The date of the criminal history record in the person of the criminal history record in the person and the job filled.  (6) The prison, jail, promise the date (7) The subsequent contains and emperson since the date (7) The subsequent contains and the job filled.  The fact of conviction shall not be a bar to end is the provider disqualic consideration of the reprovider may disclose the criminal history record.	commence with the State d check required by this siness days of the apployment by the provider. Cormation received by the all and may not be disclosed, at as provided in subsection repurposes of this 'private entity' means a gaged in conducting dischecks utilizing public in a State agency, icant's criminal history one or more convictions of a provider shall consider all is in determining whether to cousness of the crime. It is surrounding the me, if known, and the criminal conduct of the duties of the position to be obation, parole, ployment records of the other than the crime was committed, commission by the person of of a relevant offense alone employment; however, the considered by the provider.	V 133			

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STATE FORM 6899 FN8R11 If con inua ion sheet 3 of 15

DIVISION	of Health Service Re	gulation				
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
					F	
		MHL033-052	B. WING			2/2023
		WHE033-032			10/0	2/2023
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
		601 WES	T WALNUT S	TREET		
SOMEON	NE DOES CARE	TARBOR	O, NC 27886			
(VA) ID	QUIMMADV QTA	TEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTI	ON	(X5)
(X4) ID PREFIX		MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOUL		COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO	PRIATE	DATE
				DEFICIENCY)		
V 133	Continued From pa	ge 3	V 133			
	-	_				
		ry record check to the				
	applicant.					
		y A provider and an officer				
		ovider that, in good faith,				
		ection shall be immune from				
	civil liability for:					
		e provider to employ an				
		sis of information provided in				
		record check of the individual.				
		an employee's history of				
		the employee's criminal				
		k is requested and received in				
	compliance with this					
		se As used in this section,				
		neans a county, state, or				
		tory of conviction or pending				
		ne, 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;				<b> </b>
		Article 7A, Rape and Other				
	,	le 8, Assaults; Article 10,				
		duction; Article 13, Malicious				
		y Use of Explosive or				<b> </b>
		or Material; Article 14, Burglary				<b> </b>
		eakings; Article 15, Arson and				<b> </b>
		icle 16, Larceny; Article 17,				<b> </b>
	3.	, Embezzlement; Article 19,				
		d Cheats; Article 19A,				<b> </b>
	. ,	or Services by False or				<b> </b>
		Credit Device or Other Means;				<b> </b>
		al Transaction Card Crime				
	Act; Article 20, Frau	ıds; Article 21, Forgery; Article				

Division of Health Service Regulation

STATE FORM 6899 If con inua ion sheet 4 of 15 FN8R11

Division of Health Service Regulation

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. DOILDING.		   F	,
		MHL033-052	B. WING			2/2023
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
SOMEO	NE DOES CARE	601 WEST	WALNUT S	TREET		
	TE BOLO GARL	TARBORO	D, NC 27886			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROINT DEFICIENCY)	D BE	(X5) COMPLETE DATE
V 133	26, Offenses Again Decency; Article 26 Article 27, Prostitut 29, Bribery; Article Office; Article 35, C Peace; Article 36A, Article 39, Protection of the Fa Intoxication; and Ar Crime. These crime sale of drugs in viol Controlled Substan 90 of the General Soffenses such as siviolation of G.S. 18 impaired in violation G.S. 20-138.5.  (f) Penalty for Furniapplicant for employangement approximal history reconstruction of G.S. 20 Conditional Employan applicant obtaining the result check regarding the following requirement (1) The provider shippion to obtaining the criminal history reconsubsection (b) of the fingerprint cards as (2) The provider shippions days after conditional employangement of the criminal history reconsumers days after conditional employangement of the provider shippions and the provider shippions days after conditional employangement of the provider shippions days after conditional employangement applicant of the provider shippions and the provider shippions days after conditional employangement applicant of the provider shippions and the provider shippions and the provider shippions and the provider shippions and the provider shippions are provided the provided shippions and the provided shippions are provided the provided shippions and the provided shippions are provided shippions and the provided shippions	st Public Morality and 6A, Adult Establishments; ion; Article 28, Perjury; Article 31, Misconduct in Public Offenses Against the Public Riots and Civil Disorders; on of Minors; Article 40, amily; Article 59, Public ticle 60, Computer-Related es also include possession or lation of the North Carolina ces Act, Article 5 of Chapter Statutes, and alcohol-related ale to underage persons in B-302 or driving while of G.S. 20-138.1 through ishing False Information Any syment who willfully furnishes, ise gives false information on colication that is the basis for a cord check under this section Class A1 misdemeanor. Ployment A provider may at conditionally prior to so fa criminal history record es applicant if both of the	V 133			

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DIVISION	of Health Service Re	egulation				
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
					F	,
		MHL033-052	B. WING			2/2023
			l .		1070	<u> </u>
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
SOMEON	NE DOES CARE	601 WEST	TWALNUT S	TREET		
JOINLOI	IL DOLG OAKL	TARBORO	D, NC 27886			
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO		COMPLETE DATE
TAG	REGULATORT OR E	SCIDENTII TING INI ORMATION)	TAG	DEFICIENCY)	FRIATE	J
		_				
V 133	Continued From pa	ige 5	V 133			
	This Rule is not me	et as evidenced by:				
		view and interview, the facility				
	failed to ensure a c	riminal record check was				
	completed for 1 of	1 former staff (FS) (#2). The				
	findings are:					
		of FS #2's record revealed:				
	- Hired 6/23/23					
	<ul> <li>No termination</li> </ul>					
		nail thread with the following				
	messages:	20/00 f 1				
		23/23 from the Licensee to a				
		pany: "Good evening, these				
		n for a criminal check that has				
	nit been received	رادی ہے۔ 29/23 from the Licensee to a				
		pany: "Good evening i still				
		of [FS #2]'s DOP (DOB)				
		Il the information i have. May I				
		criminal check? SDC				
	(Someone Does Ca					
		Criminal Record Report (no				
		ne email thread with the				
		and conviction dates:				
	<ul> <li>First degree mi</li> </ul>	sdemeanor for Larceny				
	7/13/22	-				
		misdemeanor for Larceny				<b> </b>
	7/13/22					
		9/27/23 client #4 reported:				
		00 from client #1 "about two				
	months ago"					
		ff talking about it (FS #2				
	stealing client #1's	money)"				

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Division of Health Service Regulation

	Of Fleatur Service IN					
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
					F	,
		MHL033-052	B. WING			2/2023
		WII 12000-032			10/0	LIZUZS
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		l
COMEON	IE DOES SADE	601 WEST	WALNUT S	TREET		
SOMEON	NE DOES CARE	TARBORO	), NC 27886			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON	(X5)
PREFIX		MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL		COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROI	PRIATE	DATE
				DEFICIENCY)		
V 133	Continued From pa	ge 6	V 133			
	-					
	- FS #2 no longer worked in the facility					
	During intentions on	10/2/22 the Qualified				
	Professional (QP) r	10/2/23 the Qualified				
		rking in the facility July 2023				
		P and the Licensee were				
		uring criminal record checks				
	were completed	armig eriminar recera errecine				
		assume the duties of				
		record checks in the future				
		ed before I got here"				
		n the facility for "less than two				
		end of June 2023, but she				
	could not provide ex	•				
		censee "just found out" that FS				
		cellphone two days ago				
	(9/30/23)					
	- The Licensee a	ttempted to call client #4 and				
	FS #2 answered the	e cellphone				
	- She was unsure	e when client #4's phone was				
	stolen because clie	nt #4 did not report the stolen				
	phone					
		are of FS #2 stealing anyone				
	else's personal belo	ongings				
	Desired :	- 0/00/00 1 40/0/00 !!				
	•	n 9/28/23 and 10/2/23 the				
	Licensee reported:	ulcalana in tha for the				
		ork alone in the facility				
		n the facility for "about a week				
	or twosometime in	,				
		ecall the exact date she				
	•	out she terminated FS #2 after				
		ed and told her that FS #2				
		group home with clients				
		00 and a debit card from a				
		cility owned by the Licensee,				
		he client "gave her the money"				
		see terminated FS #2, the				
	LICENSEE Was Inforr	med by client #4 that FS #2	1			· •

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stole \$4 from client #4

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE : COMPL	
		MUI 022 052	B WING		R	
		MHL033-052	D. W.10		10/0	2/2023
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
SOMEON	NE DOES CARE		WALNUT S D, NC 27886			
(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 133	reported the \$4 stol  The Licensee at that FS #2 stole moshe could not recall stolen money  The Licensee genoney  She just found cellphone on 9/30/2  On 9/30/23, she but FS #2 answere herself  She was resported the was resported the cks were she requested in June 2023, but s  She sent anoth #2's criminal record  She could not rup with FS #2's crim 9/29/23  She reviewed Fon 9/29/23 and noting the stolen st	could not recall when client #4 en also was informed by a staff oney out of that staff's car, but I when the staff reported the lave the clients back their out that FS #2 stole client #4's 23 e attempted to call client #4, d the phone and identified ensible for ensuring criminal encompleted FS #2's criminal record check the did not receive it er request and received FS	V 133			
V 291	10A NCAC 27G .56 (a) Capacity. A factorized for the six clients when the developmental disation June 15, 2001, at than six clients at the provide services at licensed capacity.	sed Living - Operations  OPERATIONS  cility shall serve no more than eclients have mental illness or bilities. Any facility licensed and providing services to more nat time, may continue to no more than the facility's nation. Coordination shall be	V 291	To address this issue a sleep has been scheduled for the r SDC will ensure all prescribed medica aid equiment has a doctor's of These orders will be kept in a chart/MAR.	member ations ar order.	nd

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE	SURVEY LETED
ANDILAN	OF CONNECTION	BENTI TOATION NOMBER.	A. BUILDING:			
		MHL033-052	B. WING		10/0	? 2/2023
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
SOMEON	NE DOES CARE		FWALNUTS D, NC 27886			
(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)	LD BE	(X5) COMPLETE DATE
V 291	qualified profession treatment/habilitation (c) Participation of Responsible Person provided the opport relationship with he means as visits to the facility. Reports annually to the pare legally responsible Reports may be in conference and shaprogress toward modificativity opportunities needs and the treat Activities shall be dinclusion. Choices or legal system is in the system of the system	n the facility operator and the sals who are responsible for on or case management. The Family or Legally n. Each client shall be tunity to maintain an ongoing or or his family through such the facility and visits outside a shall be submitted at least ent of a minor resident, or the person of an adult resident. Writing or take the form of a sall focus on the client's eeting individual goals. Each client shall have s based on her/his choices, tement/habilitation plan. The signed to foster community may be limited when the court involved or when health or one a primary concern.	V 291			
	Based on record re interview, the facilit	et as evidenced by: view, observation and y failed to coordinate with to meet the needs of 1 of 3 . The findings are:				
	<ul> <li>Admitted 1/4/12</li> <li>Diagnoses of H Seizure Disorder, D Developmental Dis Abuse</li> <li>No physician's</li> </ul>	of client #5's record revealed: 2 lyperlipemia, Hypertension, Depression, Intellectual order, Hand Injury, and Alcohol order for client #5 to use a airway pressure (CPAP)				

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DIVISION	of Health Service Re	guiation				
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
					-	,
		MUI 022 052	MHL033-052 B. WING R			
		WIHL033-032			10/0	2/2023
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
		601 WES	WALNUT S	TREET		
SOMEO	NE DOES CARE		D, NC 27886			
	CUMMADY CTA	TEMENT OF DEFICIENCIES			DNI .	0/5)
(X4) ID PREFIX		/ MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
TAG	<b>\</b>	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO		DATE
				DEFICIENCY)		
1/ 004	0		V/ 004			
V 291	Continued From pa	ige 9	V 291			
	During observation	and interview on 10/2/23 at				
	2:32pm client #5 re					
		AP machine was not visible in				
		and client #5 didn't know				
	where his CPAP ma					
		idn't ordered one (CPAP				
		e he threw his last CPAP				
	, ,					
	machine away in No					
		sed to wear the CPAP machine				
	every night					
	- He "slept well" \	without the CPAP machine				
	D					
		and interview on 10/2/23 at				
	2:23pm staff #1 rep					
		in client #5's bedroom but				
		ent #5's CPAP machine				
		ng on getting it (CPAP				
	machine) back in pl					
		supposed to get the mask for				
		t his Primary Care Provider				
	(PCP) appointment					
		nute (a long time) since he				
	(client #5) used it (0	•				
		t used a CPAP machine in				
	months					
	- "He (client #5) (	don't like it (CPAP machine)"				
		2/23 at 2:54pm in client #5's				
		view with the Qualified				
	Professional (QP) r					
		client #5 where his CPAP				
	machine was					
		client #5's CPAP machine				
	from the bottom of					
		chine was inside of a carry bag				
	with the hose detac	hed and there was no water				
	inside the humidifie	r water tub				
	- Client #5 was s	supposed to get his mask				
	"refitted" for the CP					

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Division of Health Service Regulation

	of Health Service Re	I				
	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPI	LETED
					F	≀
		MHL033-052	B. WING			2/2023
NAME OF	200/4050 00 01400450	OTDEET AD	PPEGG OFFICE	714TF 7ID 00DF		
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
SOMEO	NE DOES CARE		T WALNUT S			
		TARBOR	D, NC 27886			
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	,	/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI		COMPLETE DATE
IAO			IAG	DEFICIENCY)		
V 291	Cantinuad Francis	10	V 291			
V 291	Continued From pa		V 231			
		e when client #5 last used his				
	CPAP machine					
		ny distilled water in the CPAP				
	machine	E CH L L L C L C CDAD				
		distilled water for his CPAP				
	Licensee's office	water would be kept in the				
		ecall if client #5 had distilled				
	water for his CPAP					
		don't like it (CPAP machine)				
	he can't breathe wit					
	- Client #5 had a	n appointment with his PCP				
	today (10/2/23)					
		AP machine needed to be				
	"calibrated"					
		new PCP and he was				
	supposed to be doi					
		scheduled another PCP				
	machine calibrated	ent #5 to get his CPAP				
		vas responsible for				
		' doctor appointments				
	<b>_</b>	ат эт аррания				
	During interview on	10/2/23 the Licensee				
	reported:					
		esponsible for coordinating the				
	clients' doctor appo					
		supposed to use his CPAP				
	machine every nigh					
		away his last CPAP machine y client #5's previous PCP that				
		e one (new CPAP machine)				
	for a few years"	constitution of the machine)				
		client #5 a CPAP machine				
	that she no longer					
		e to verify if the donated CPAP				
	machine was disinf					
		supposed to have his mask				
		nachine "calibrated" today				
	(10/2/23), but the s	taff "forgot" to take the CPAP				

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	SURVEY LETED
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING:		COMP	LETED
		MHL033-052	B. WING		10/0	? 2/2023
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
SOMEON	SOMEONE DOES CARE			TREET		
	TE BOLO CARL	TARBORO	D, NC 27886	<u> </u>		
(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 APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
V 291	Continued From pa	ge 11	V 291			
	CPAP machine - Staff was suppreclient #5 was puttin #5 didn't like using This deficiency con and must be correct	e if client #5 was using the cosed to check to make sure g the CPAP on because client the CPAP machine stitutes a re-cited deficiency cted within 30 days.				
V 736	27G .0303(c) Facili	ty and Grounds Maintenance	V 736			
	EXTERIOR REQUI (c) Each facility and maintained in a saf	303 LOCATION AND IREMENTS I its grounds shall be e, clean, attractive and orderly e kept free from offensive				
		ion and interview, the facility I in a safe and attractive				
	- A crack approx	Opm on 10/2/23 revealed: imately 1 foot in the nt #4's bedroom window				
	<ul> <li>She could not r windowpane</li> <li>She saw the cr months ago"</li> <li>She did not tell was cracked</li> </ul>	10/2/23 client #4 reported: recall what happened to the acked window a "couple anyone that her windowpane 10/2/23 the Qualified reported:				
		are of the cracked				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED				
			71. 001.251110.		R				
		MHL033-052	B. WING		10/02/2023				
NAME OF F	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE								
SOMEONE DOES CARE 601 WEST WALNUT STREET TARBORO, NC 27886									
(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 SHOULD CROSS-REFERENCED TO THE APPROVIDENCY)	LD BE COMPLETE				
V 736	windowpane in client #4's bedroom  - "Not one set person" was responsible doing walkthroughs of the facility and reporting needed repairs  - Staff should report damages to the Licensee to be repaired  During interview on 10/2/23 the Licensee reported:  - She was responsible for overseeing repairs,			To address V 784, the windowas repaired 11/10/2023.  QP's are tasks with complet walkthoughs of the home ar and repairs needed and issue to the owner.	ing monthly ad report				
	damages - She was unawa windowpane in clier - She planned to soon as possible"  This deficiency con and must be correct	have the window repaired "as stitutes a re-cited deficiency ted within 30 days.							
V 784	Areas  10A NCAC 27G .03 EQUIPMENT (d) Indoor space reprior to October 1, square footage requires. Unless otherwresidential facilities 1988 shall meet the requirements: (12) The area in whabilitative activities be separate from slipping to the separate from slipping to the separate shall be separate from slipping to the separate shall be shall be separate shall be separate shall be separa		V 784	To address this area the age ensure no staff persons are sleeping in the group home under any cirucmstance. The that violate this policy will be and replacement staff will be to cover their shift. This will taimmediately.	ese termindated in place				
	This Rule is not me Based on record re	et as evidenced by: view and interview, the facility							

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CL IDENTIFICATION NUMBER		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED			
		IDENTIFICATION NUMBER:						
					F	,		
		MHL033-052	B. WING					
		WIHE033-052			10/0	2/2023		
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE				
		601 WES	T WALNUT S	TREET				
SOMEON	NE DOES CARE							
			D, NC 27886					
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION SHOULD		(X5)		
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETE DATE		
IAO			IAG					
V 784	Continued From page 13		V 784					
	failed to ensure therapeutic and habilitative							
		conducted were separate from						
	the sleeping area.							
	ille sieepilig alea.	The linulings are.						
	Review on 10/2/22	of Former Staff (FS) #2's						
	record revealed:	of Former Stall (FS) #25						
	- Hired 6/23/23							
	- No termination	data						
	- No termination	uale						
	During interview on	10/2/23 the Qualified						
	During interview on 10/2/23 the Qualified							
	Professional reported: - FS #2 previously reported to her and the							
	Licensee that she was "homeless"							
	- She walked into the facility "around 12pm"							
	and saw FS #2 asleep on the living room sofa  - The incident occurred around the last week of July 2023 or first week of August 2023, but she							
	could not recall the							
	<ul> <li>FS #2 was still employed at the facility and she had just finished working a 7pm to 7am shift</li> <li>When she saw FS #2 asleep on the couch, she called the Licensee</li> <li>The Licensee told FS #2 that she could not</li> </ul>							
	"sleep on the sofa"	and FS #2 "got up and left"						
	During interview on 10/2/23 the Licensee reported:							
						<b> </b>		
	- FS #2 came to the facility one day and told							
	her that she "didn't have anywhere to go"					<b> </b>		
	- She could not recall the exact date of the incident, but FS #2 no longer worked for the							
		no longer worked for the				<b> </b>		
	facility at the time	C #2) aloon on the sough for 4				<b> </b>		
		S #2) sleep on the couch for 4				<b> </b>		
		(FS #2) she needed to leave				<b> </b>		
		this was a licensed facility"				<b> </b>		
		elt that she had a "good heart"				<b> </b>		
	and she "felt bad" f							
		that she was previously cited				<b> </b>		
		on the sofa in the facility when				<b> </b>		
	she allowed FS #2	to sleep on the sofa for 4						

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED				
AND PLAN OF CORRECTION		IDENTIFICATION NOWIBER.	A. BUILDING:	<u> </u>					
		MHL033-052	B. WING		10/0	2/2023			
NAME OF F	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE								
SOMEONE DOES CARE 601 WEST WALNUT STREET TARBORO, NC 27886									
(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 784	Continued From page 14		V 784						
	hours								
		stitutes a re-cited deficiency sted within 30 days.							

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