STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL044-036	A. BUILDING: _____ B. WING _____	R 10/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAYWOOD COUNTY GROUP HOME #4	185 FARLEY STREET WAYNESVILLE, NC 28786

(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 An annual, complaint, and follow up survey was completed on October 31, 2023. The complaint was substantiated (NC#00207926). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disability. This facility is licensed for 6 and currently has a census of 6. The survey sample consisted of audits of 3 current clients.	V 000		
V 109	27G .0203 Privileging/Training Professionals 10A NCAC 27G .0203 COMPETENCIES OF QUALIFIED PROFESSIONALS AND ASSOCIATE PROFESSIONALS (a) There shall be no privileging requirements for qualified professionals or associate professionals. (b) Qualified professionals and associate professionals shall demonstrate knowledge, skills and abilities required by the population served. (c) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence. (d) Competence shall be demonstrated by exhibiting core skills including: (1) technical knowledge; (2) cultural awareness; (3) analytical skills; (4) decision-making; (5) interpersonal skills; (6) communication skills; and (7) clinical skills. (e) Qualified professionals as specified in 10A NCAC 27G .0104 (18)(a) are deemed to have met the requirements of the competency-based	V 109		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL044-036	A. BUILDING: _____ B. WING _____	R 10/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAYWOOD COUNTY GROUP HOME #4	185 FARLEY STREET WAYNESVILLE, NC 28786

(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 109	Continued From page 1 employment system in the State Plan for MH/DD/SAS. (f) The governing body for each facility shall develop and implement policies and procedures for the initiation of an individualized supervision plan upon hiring each associate professional. (g) The associate professional shall be supervised by a qualified professional with the population served for the period of time as specified in Rule .0104 of this Subchapter. This Rule is not met as evidenced by: Based on record review and interview, 1 of 2 Qualified Professionals, (Executive Director/Qualified Professional #1 (ED/QP #1)) failed to demonstrate the knowledge, skills, and abilities required by the population served. The findings are: Review on 10/26/23 of the ED/QP #1's personnel record revealed: -Hire date: 4/21/22. -Title: Executive Director. -Job Description signed 3/19/22, "Duties and Responsibilities: Administration/Management ... Carries out policies and procedures of the organization as adopted by the Board ...Provides Direct Supervision ...to staff as necessary to ensure compliance with local and state agencies and affiliates ...Ensure that all state and federal work standards are met and that all employees meet state licensure requirements ...set by ...Division of Facility Services ...Acquire and maintain	V 109		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL044-036	A. BUILDING: _____ B. WING _____	R 10/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAYWOOD COUNTY GROUP HOME #4	185 FARLEY STREET WAYNESVILLE, NC 28786

(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 109	Continued From page 2 knowledge of program standards, ensuring all operations are in accordance with licensing and regulatory requirements ...during inspections and surveys coordinating any resulting changes necessary to assure all standards are met." Review on 10/24/23 of of the internal investigation notes provided by the Human Resource (HR) Director revealed: -received text from ED/QP #1 on 7/17/23, "that there had been a report regarding an individual (Client #2) had been pushed in the bathroom at the facility by [Former Staff #3 (FS #3)] and had a bruise on her eye." -reviewed video footage remotely but could not hear the audio. -"told him (ED/QP #1) that once I returned to the office would be able to login and hear and see." -returned to the office on 7/20/23. Review on 10/24/23 of the facility's internal investigation notes written by the ED/QP #1 revealed: -7/17/23 " ... [Day Program Administrator] phone call, bruise over L (left) eyelid, very consistent with story (Client #2) ...nose a little red ...lower lip ...said she wasn't afraid to go home ...just when [FS #3] is upset." Interview on 10/30/23 and 10/31/23 with the ED/QP #1 revealed: -did not protect the client during the investigation, allowing FS #3 to remain working with Client #2. -did not seek medical attention for Client #2 per policy. -"got a phone call from [Day Program Administrator] on 7/17/23 that [Client #2] had a bruise on her face and that she (Client #2) reported [FS #3] had pushed her in the bathroom."	V 109		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL044-036	A. BUILDING: _____ B. WING _____	R 10/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAYWOOD COUNTY GROUP HOME #4	185 FARLEY STREET WAYNESVILLE, NC 28786

(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 109	Continued From page 3 -"immediately" had HR Director review camera footage of the facility from the time frame reported by Client #2. - couldn't prove physical abuse because they don't have cameras in the bathroom or bedrooms. -"had technological difficulties and couldn't access audio footage." -"could see (witness) the verbal abuse later (on camera)." -"If I had known that Friday (7/17/23) (verbal abuse) she (FS #3) would have been gone immediately." -facility staff did not take pictures of Client #2's face. -there was no General Events Report (GER)/ (internal incident report) in Client #2's record regarding bruises. -thought that the North Carolina Incident Response Improvement System (IRIS) notified the local Department of Social Services. -FS #3 was terminated on 7/20/23. -the delay in terminating FS #3 was "due to technology." -"Can't plead ignorance ...I know how this looks on paper." This deficiency is cross referenced into 10A NCAC 27D .0304 Protection from Harm, Abuse, Neglect or Exploitation (V512) for a Type A1 rule violation and must be corrected within 23 days.	V 109		
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	V 132		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL044-036	A. BUILDING: _____ B. WING _____	R 10/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAYWOOD COUNTY GROUP HOME #4	185 FARLEY STREET WAYNESVILLE, NC 28786

(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 132	Continued From page 4 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 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.	V 132		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL044-036	A. BUILDING: _____ B. WING _____	R 10/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAYWOOD COUNTY GROUP HOME #4	185 FARLEY STREET WAYNESVILLE, NC 28786

(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 132	Continued From page 5	V 132		

This Rule is not met as evidenced by:
Based on record review and interview, the facility failed to investigate all allegations of abuse and failed to protect the client during an internal investigation for 1 of 3 audited clients (Client #2). The findings are:

Review on 10/24/23 of Client #2's record revealed:
-Admission Date: 2/8/20.
-Diagnoses: Mild Intellectual Developmental Disability (IDD), Autism, Bipolar Disorder (D/O), Schizoaffective D/O, Anxiety, Non-Organic Psychosis, Depression, Neuroleptic Malignant Syndrome, Hypothyroidism, and Heavy Periods.

Review on 10/24/23 of the facility's internal investigation notes written by Executive Director/Qualified Professional #1 (ED/QP #1) and Human Resource (HR) Director revealed:
-facility was aware of abuse allegations against Former Staff #3 (FS #3) on 7/17/23.
-facility terminated FS #3 on 7/20/23.

Interview on 10/26/23 with Client #2's Day Program Administrator revealed:
-Client #2 came to the day program on 7/17/23 with a bruised eyelid and lip.
-"[Client #2] was consistent with her story ... [Former Staff #3 (FS #3)] pushed her in the bathroom and told her she (Client #2) was acting like a child and could send her to a homeless shelter."
-took pictures of Client #2's face on 7/17/23 and 7/18/23.
-spoke with the ED/QP #1 of the facility on 7/17/23 about the bruising to Client #2's face and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL044-036	A. BUILDING: _____ B. WING _____	R 10/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAYWOOD COUNTY GROUP HOME #4	185 FARLEY STREET WAYNESVILLE, NC 28786

(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 132	Continued From page 6 abuse allegations against FS #3. Interview on 10/26/23 with Day Program Staff #1 revealed: -observed FS #3 drop Client #2 and her housemates off at the day program after the allegations of abuse against FS #3 were reported on 7/17/23. Interview on 10/31/23 with Staff #1 revealed: -she and FS #3 were working at the facility on 7/17/23. -confirmed she and FS #3 continued to work at the facility for the next few days (after 7/17/23). -FS #3 was called to the office on 7/20/23 and left the facility. -"nothing was said to me." -"[Client #2] did have a small bruise on her upper eyelid." -FS #3 told me "the day after the street dance (7/18/23), [Client #2] had fallen getting out of the shower ...slipped and hit her eye." -FS #3 told me she "was reporting it to me and that she (FS #3) was going to sit down and write a General Events Report (GER)/(internal incident report)." -it was normal practice to submit a GER for an injury and then notify the group home coordinator and guardian. Interview on 10/25/23 with Client #2's guardian revealed: -"I'm used to the group home staff calling me immediately and letting me know if something happened (with Client #2), this time they didn't." -became aware of what happened because she received a call from the day program. -"I didn't get a call from the group home so I texted [FS #3] and called her myself (on 7/19/23)."	V 132		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL044-036	A. BUILDING: _____ B. WING _____	R 10/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAYWOOD COUNTY GROUP HOME #4	185 FARLEY STREET WAYNESVILLE, NC 28786

(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 132	Continued From page 7 -"[FS #3]... had stopped [Client #2] from falling in the bathroom when she was getting out (of the shower) and I said 'ok, but she has a bruise on her eyelid and bridge of nose, you got to let me know ...[FS #3] said ok.' " -contacted the ED/QP #1 on 7/19/23. -ED/QP #1 later told her that FS #3 was terminated. Interview on 10/30/23 with the Qualified Professional #2 (QP #2) revealed: -was out of town on 7/17/23 when the call came in about Client #2. -spoke to Client #2 on 7/19/23 when she returned to the office. -saw a bruise that was faded on Client #2 and "saw something on her lip ...I know it was fading out (bruise)." -attempted to interview Client #2 about what happened, "all she would say is 'I don't want to get people in trouble. '" -facility staff did not take pictures of Client #2. -not sure why FS #3 continued to work at the facility while there were allegations of abuse, " ...you have to put staff on admin (administrative) leave when there are any allegations of abuse, whether they are true or not." This deficiency is cross referenced into 10A NCAC 27D .0304 Protection from Harm, Abuse, Neglect or Exploitation (V512) for a Type A1 rule violation and must be corrected within 23 days.	V 132		
V 291	27G .5603 Supervised Living - Operations 10A NCAC 27G .5603 OPERATIONS (a) Capacity. A facility shall serve no more than six clients when the clients have mental illness or developmental disabilities. Any facility licensed	V 291		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL044-036	A. BUILDING: _____ B. WING _____	R 10/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAYWOOD COUNTY GROUP HOME #4	185 FARLEY STREET WAYNESVILLE, NC 28786

(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 291	Continued From page 8 on June 15, 2001, and providing services to more than six clients at that time, may continue to provide services at no more than the facility's licensed capacity. (b) Service Coordination. Coordination shall be maintained between the facility operator and the qualified professionals who are responsible for treatment/habilitation or case management. (c) Participation of the Family or Legally Responsible Person. Each client shall be provided the opportunity to maintain an ongoing relationship with her or his family through such means as visits to the facility and visits outside the facility. Reports shall be submitted at least annually to the parent of a minor resident, or the legally responsible person of an adult resident. Reports may be in writing or take the form of a conference and shall focus on the client's progress toward meeting individual goals. (d) Program Activities. Each client shall have activity opportunities based on her/his choices, needs and the treatment/habilitation plan. Activities shall be designed to foster community inclusion. Choices may be limited when the court or legal system is involved or when health or safety issues become a primary concern. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to coordinate services with those persons responsible for the client's care affecting 1 of 3 audited clients (Client #2). The findings are: Review on 10/24/23 of Client #2's record revealed: -Admission Date: 2/8/20. -Diagnoses: Mild Intellectual Developmental	V 291		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL044-036	A. BUILDING: _____ B. WING _____	R 10/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAYWOOD COUNTY GROUP HOME #4	185 FARLEY STREET WAYNESVILLE, NC 28786

(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 291	Continued From page 9 Disability (IDD), Autism, Bipolar Disorder (D/O), Schizoaffective D/O, Anxiety, Non-Organic Psychosis, Depression, Neuroleptic Malignant Syndrome, Hypothyroidism, and Heavy Periods. Interview on 10/26/23 with Client #2's Day Program Administrator revealed: -Client #2 came to the day program on 7/17/23 with a bruised eyelid and lip. -"[Client #2] was consistent with her story ... [Former Staff #3 (FS #3)] pushed her in the bathroom and told her she (Client #2) was acting like a child and could send her to a homeless shelter." -contacted the Executive Director/Qualified Professional #1 (ED/QP #1) on 7/17/23 about the bruising on Client #2's face and abuse allegations made against FS #3. Interview on 10/25/23 with Client #2's guardian revealed: -became aware of what happened because she received a call from the day program on 7/17/23. -"I'm used to the group home staff calling me immediately and letting me know if something happened (with Client #2), this time they didn't." -she first spoke to the ED/QP #1 on 7/19/23, when she contacted him and he called her back. -No one from the group home called her about what happened, she called facility staff herself. -not aware if her sister was taken to get medical care. Interview on 10/26/23 with Client #2's Care Coordinator revealed: -did not receive a call from facility staff regarding incident with Client #2. -observed Client #2 to have a bruised eyelid and swollen lip on 7/19/23 during a scheduled visit. -Client #2's "eyelid was blue and lip was swollen."	V 291		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL044-036	A. BUILDING: _____ B. WING _____	R 10/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAYWOOD COUNTY GROUP HOME #4	185 FARLEY STREET WAYNESVILLE, NC 28786

(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 291	Continued From page 10 -told the facility that they needed to file an Incident report in IRIS (North Carolina Incident Response Improvement System). Interview on 10/30/23 and 10/31/23 with the ED/QP #1 revealed: -did speak with Client #2's guardian. -not sure if Client #2 received medical treatment.	V 291		
V 318	13O .0102 HCPR - 24 Hour Reporting 10A NCAC 13O .0102 INVESTIGATING AND REPORTING HEALTH CARE PERSONNEL The reporting by health care facilities to the Department of all allegations against health care personnel as defined in G.S. 131E-256 (a)(1), including injuries of unknown source, shall be done within 24 hours of the health care facility becoming aware of the allegation. The results of the health care facility's investigation shall be submitted to the Department in accordance with G.S. 131E-256(g). This Rule is not met as evidenced by: Based on record review and interview, the facility failed to notify the Health Care Personnel Registry (HCPR) of allegations against a health care personnel within 24 hours of the facility becoming aware of the allegation. The findings are:	V 318		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL044-036	A. BUILDING: _____ B. WING _____	R 10/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAYWOOD COUNTY GROUP HOME #4	185 FARLEY STREET WAYNESVILLE, NC 28786

(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 318	Continued From page 11 Review on 10/24/23 of Client #2's record revealed: -Admission Date: 2/8/20. -Diagnoses: Mild Intellectual Developmental Disability (IDD), Autism, Bipolar Disorder (D/O), Schizoaffective D/O, Anxiety, Non-Organic Psychosis, Depression, Neuroleptic Malignant Syndrome, Hypothyroidism, and Heavy Periods. Review on 10/23/23 of the North Carolina Incident Response Improvement System (IRIS) revealed: -7/19/23, Level II incident report completed by the day program staff for "physical and verbal abuse allegations against group home staff ...7/17/2023, [Client #2] said that her group home staff pushed her and said she was acting like a child and could be sent to a homeless shelter." -7/20/23, Level III incident report completed by the facility, "Provider received an external report from another agency claiming that the individual (Client #2) was physically and verbally abused by the Group Home manager." Interview on 10/19/23 and 10/26/23 with the Client #2's Day Program Administrator revealed: -contacted the Executive Director/Qualified Professional #1 (ED/QP #1) on 7/17/23 about the bruising on Client #2's face and abuse allegations against FS #3. -North Carolina Incident Response Improvement System (IRIS) staff contacted her on 8/8/23 to submit a Level III incident report and they reported they hadn't received a report from the facility. Interview on 10/30/23 and 10/31/23 with the ED/QP #1 revealed: -did notify Health Care Personnel Registry (HCPR) after they did their internal investigation. -did not realize that HCPR notification had to be	V 318		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL044-036	A. BUILDING: _____ B. WING _____	R 10/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAYWOOD COUNTY GROUP HOME #4	185 FARLEY STREET WAYNESVILLE, NC 28786

(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 318	Continued From page 12 completed within 24 hours when there were allegations against staff.	V 318		
V 366	27G .0603 Incident Response Requirments 10A NCAC 27G .0603 INCIDENT RESPONSE REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall develop and implement written policies governing their response to level I, II or III incidents. The policies shall require the provider to respond by: (1) attending to the health and safety needs of individuals involved in the incident; (2) determining the cause of the incident; (3) developing and implementing corrective measures according to provider specified timeframes not to exceed 45 days; (4) developing and implementing measures to prevent similar incidents according to provider specified timeframes not to exceed 45 days; (5) assigning person(s) to be responsible for implementation of the corrections and preventive measures; (6) adhering to confidentiality requirements set forth in G.S. 75, Article 2A, 10A NCAC 26B, 42 CFR Parts 2 and 3 and 45 CFR Parts 160 and 164; and (7) maintaining documentation regarding Subparagraphs (a)(1) through (a)(6) of this Rule. (b) In addition to the requirements set forth in Paragraph (a) of this Rule, ICF/MR providers shall address incidents as required by the federal regulations in 42 CFR Part 483 Subpart I. (c) In addition to the requirements set forth in Paragraph (a) of this Rule, Category A and B providers, excluding ICF/MR providers, shall develop and implement written policies governing their response to a level III incident that occurs	V 366		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL044-036	A. BUILDING: _____ B. WING _____	R 10/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAYWOOD COUNTY GROUP HOME #4	185 FARLEY STREET WAYNESVILLE, NC 28786

(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 366	Continued From page 13	V 366		

while the provider is delivering a billable service or while the client is on the provider's premises. The policies shall require the provider to respond by:
(1) immediately securing the client record by:
(A) obtaining the client record;
(B) making a photocopy;
(C) certifying the copy's completeness; and
(D) transferring the copy to an internal review team;
(2) convening a meeting of an internal review team within 24 hours of the incident. The internal review team shall consist of individuals who were not involved in the incident and who were not responsible for the client's direct care or with direct professional oversight of the client's services at the time of the incident. The internal review team shall complete all of the activities as follows:
(A) review the copy of the client record to determine the facts and causes of the incident and make recommendations for minimizing the occurrence of future incidents;
(B) gather other information needed;
(C) issue written preliminary findings of fact within five working days of the incident. The preliminary findings of fact shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different; and
(D) issue a final written report signed by the owner within three months of the incident. The final report shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different. The final written report shall address the issues identified by the internal review team, shall include all public documents pertinent to the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL044-036	A. BUILDING: _____ B. WING _____	R 10/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAYWOOD COUNTY GROUP HOME #4	185 FARLEY STREET WAYNESVILLE, NC 28786

(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 366	Continued From page 14 incident, and shall make recommendations for minimizing the occurrence of future incidents. If all documents needed for the report are not available within three months of the incident, the LME may give the provider an extension of up to three months to submit the final report; and (3) immediately notifying the following: (A) the LME responsible for the catchment area where the services are provided pursuant to Rule .0604; (B) the LME where the client resides, if different; (C) the provider agency with responsibility for maintaining and updating the client's treatment plan, if different from the reporting provider; (D) the Department; (E) the client's legal guardian, as applicable; and (F) any other authorities required by law. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to implement their written policies governing their response to Level II or Level III incidents. The findings are: Review on 10/24/23 of Client #2's record revealed: -Admission Date: 2/8/20. -Diagnoses: Mild Intellectual Developmental Disability (IDD), Autism, Bipolar Disorder (D/O), Schizoaffective D/O, Anxiety, Non-Organic Psychosis, Depression, Neuroleptic Malignant	V 366		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL044-036	A. BUILDING: _____ B. WING _____	R 10/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAYWOOD COUNTY GROUP HOME #4	185 FARLEY STREET WAYNESVILLE, NC 28786

(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 366	Continued From page 15 Syndrome, Hypothyroidism, and Heavy Periods. Further Review on 10/24/23 of Client #2's record revealed: -no General Event Reports (GERs/internal incident reports) (any levels) for Client #2 from 6/28/23 to 10/24/23. Review on 10/23/23 of the North Carolina Incident Response Improvement System (IRIS) revealed: -Level III incident report completed by the facility, 7/20/2023, "Provider received an external report from another agency claiming that the individual (Client #2) was physically and verbally abused by the Group Home manager ... The initial allegation could not be proven for lack of evidence.." -there was no documentation that showed risk cause analysis of the incident; if the facility developed and implemented corrective measures to prevent similar incidents in the future or assigned staff to be responsible for implementing corrections or preventative measures. -the facility failed to submit their preliminary findings (of their investigation) within 5-days to the Local Management Entity/Managed Care Organization (LME/MCO). Interview on 10/30/23 and 10/31/23 with the Executive Director/Qualified Professional #1 (ED/QP #1) revealed: -notified Health Care Personnel Registry (HCPR) after the facility completed their investigation. -acknowledged that the facility had a policy, "#404" that outlined the response to allegations of abuse, neglect, and exploitation of individuals that wasn't followed. -would review the policy as part of their plan of correction.	V 366		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL044-036	A. BUILDING: _____ B. WING _____	R 10/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAYWOOD COUNTY GROUP HOME #4	185 FARLEY STREET WAYNESVILLE, NC 28786

(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 367	Continued From page 16	V 367		
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 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	V 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL044-036	A. BUILDING: _____ B. WING _____	R 10/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAYWOOD COUNTY GROUP HOME #4	185 FARLEY STREET WAYNESVILLE, NC 28786

(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 367	Continued From page 17 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 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	V 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL044-036	A. BUILDING: _____ B. WING _____	R 10/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAYWOOD COUNTY GROUP HOME #4	185 FARLEY STREET WAYNESVILLE, NC 28786

(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 367	Continued From page 18 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: Based on record review and interview, the facility failed to report all level III incidents to the Local Management Entity (LME)/Managed Care Organization (MCO) as required within 72 hours of becoming aware of the incident. The findings are: Review on 10/24/23 of Client #2's record revealed: -Admission Date: 2/8/20. -Diagnoses: Mild Intellectual Developmental Disability (IDD), Autism, Bipolar Disorder (D/O), Schizoaffective D/O, Anxiety, Non-Organic Psychosis, Depression, Neuroleptic Malignant Syndrome, Hypothyroidism, and Heavy Periods. Further Review on 10/24/23 of Client #2's record revealed: -no General Event Reports (GERs/internal incident reports) (any levels) for Client #2 from 6/28/23 to 10/24/23. Interview on 10/26/23 with Client #2's Day Program Administrator revealed: -Client #2 came to the day program on 7/17/23 with a bruised eyelid and lip. -"[Client #2] was consistent with her story ..." -contacted the Executive Director/Qualified	V 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL044-036	A. BUILDING: _____ B. WING _____	R 10/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAYWOOD COUNTY GROUP HOME #4	185 FARLEY STREET WAYNESVILLE, NC 28786

(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 367	Continued From page 19 Professional #1 (ED/QP #1) on 7/17/23 about bruising on Client #2's face and abuse allegations (physical and verbal) made against Former Staff #3 (FS #3). Review on 10/23/23 of the North Carolina Incident Response Improvement System (IRIS) revealed: -Level III incident report completed by the facility, 7/20/2023, "Provider received an external report from another agency claiming that the individual (Client #2) was physically and verbally abused by the Group Home manager ... The initial allegation could not be proven for lack of evidence." -"Allegation of Abuse, Neglect, or Exploitation ...check all that apply: Verbal Abuse." -physical abuse allegations (made by Client #2 against Former Staff #3) that were reported to the ED/QP #1 on 7/17/23, including bruising to Client #2's eye and lip were not included in the incident report. -individuals notified or authorities responding to Client #2's physical abuse allegations were not documented. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	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	V 500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL044-036	A. BUILDING: _____ B. WING _____	R 10/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAYWOOD COUNTY GROUP HOME #4	185 FARLEY STREET WAYNESVILLE, NC 28786

(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 500	Continued From page 20 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 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	V 500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL044-036	A. BUILDING: _____ B. WING _____	R 10/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAYWOOD COUNTY GROUP HOME #4	185 FARLEY STREET WAYNESVILLE, NC 28786

(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 500	Continued From page 21 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 review and interview, the facility failed to ensure all instances of alleged abuse and neglect were reported to the local Department of Social Services (DSS) affecting 1 of 3 audited clients, (Client #2). The findings are: Review on 10/23/23 of the North Carolina Incident Response Improvement System (IRIS) revealed: -Level III incident report, 7/20/2023, "Provider received an external report from another agency claiming that the individual was physically and verbally abused by Group Home manager ..." Interview on 10/30/23 with the Executive Director/Qualified Professional #1 revealed: -learned about abuse allegations regarding Client #2 on 7/17/23. -did not notify the local Department of Social Services.	V 500		
V 512	27D .0304 Client Rights - Harm, Abuse, Neglect 10A NCAC 27D .0304 PROTECTION FROM HARM, ABUSE, NEGLECT OR EXPLOITATION (a) Employees shall protect clients from harm,	V 512		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL044-036	A. BUILDING: _____ B. WING _____	R 10/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAYWOOD COUNTY GROUP HOME #4	185 FARLEY STREET WAYNESVILLE, NC 28786

(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 512	Continued From page 22 abuse, neglect and exploitation in accordance with G.S. 122C-66. (b) Employees shall not subject a client to any sort of abuse or neglect, as defined in 10A NCAC 27C .0102 of this Chapter. (c) Goods or services shall not be sold to or purchased from a client except through established governing body policy. (d) Employees shall use only that degree of force necessary to repel or secure a violent and aggressive client and which is permitted by governing body policy. The degree of force that is necessary depends upon the individual characteristics of the client (such as age, size and physical and mental health) and the degree of aggressiveness displayed by the client. Use of intervention procedures shall be compliance with Subchapter 10A NCAC 27E of this Chapter. (e) Any violation by an employee of Paragraphs (a) through (d) of this Rule shall be grounds for dismissal of the employee. This Rule is not met as evidenced by: Based on record review, interview, and observation 1 of 1 audited former staff (Former Staff #3 (FS #3)) abused and 1 of 4 audited staff (Executive Director/Qualified Professional #1 (ED/QP#1)) neglected 1 of 3 audited clients (Client #2). The findings are: Cross Reference: 10A NCAC 27G .0203 Competencies of Qualified Professionals and Associate Professionals (V109). Based on record review and interview, 1 of 2 Qualified Professionals, (Executive Director/Qualified Professional #1 (ED/QP#1)) failed to demonstrate the knowledge, skills, and abilities required by the	V 512		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL044-036	A. BUILDING: _____ B. WING _____	R 10/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAYWOOD COUNTY GROUP HOME #4	185 FARLEY STREET WAYNESVILLE, NC 28786

(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 512	Continued From page 23 population served. Cross Reference: GS 131E-256 Health Care Personnel Registry (V132). Based on record review and interview, the facility failed to investigate all allegations of abuse and failed protect the client during an internal investigation for 1 of 3 audited clients (Client #2). Review on 10/24/23 of Client #2's record revealed: -no General Event Reports (GERs)/(internal incident reports) (any levels) for Client #2 from 6/28/23 to 10/24/23. -No documentation of injuries or falls in T-Logs (behavior logs/progress notes) from 7/1/23 to 7/31/23. Review on 10/24/23 of FS #3's personnel record revealed: -Hire Date: 5/8/11. -Position: Group Home Coordinator, effective 6/9/22. -Termination Date: 7/20/23. Review on 10/25/23 of photographs taken by Client #2's Day Program Administrator of Client #2's face revealed: -a red-purple bruise on inner left eyelid and a purple bruise on her bottom lower lip (left side) dated 7/17/23. -7/18/23 (Day 2) her left eye lid was a darker purple almost blue, that covered all of her lower eyelid. -7/18/23 purple bruise on the lower left side of her bottom lip. Observation and Interview on 10/25/23 at 4:15PM with Client #2 revealed: -mumbling under her breath;	V 512		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL044-036	A. BUILDING: _____ B. WING _____	R 10/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAYWOOD COUNTY GROUP HOME #4	185 FARLEY STREET WAYNESVILLE, NC 28786

(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 512	Continued From page 24 -kept repeating that she liked living here (at the facility), "everything was fine." -did not want to talk about FS #3. Interview on 10/19/23 and 10/26/23 with Client #2's Day Program Administrator revealed: -Client #2 came to the day program on 7/17/23 with a bruised eyelid and lip. - took pictures of Client #2's face on 7/17/23 and 7/18/23. -spoke with the Executive Director/Qualified Professional #1 (ED/QP #1) of the facility on 7/17/23 about the bruising to Client #2's face and abuse allegations against FS #3. -Day Program Staff #1 observed FS #3 continuing to drop off clients in the morning from the group home after they notified the facility of the allegations on 7/17/23. Interview on 10/25/23 with Client #2's guardian revealed: -FS #3's tone of voice was "rough" but credited Client #2's progress in the facility because of FS #3. -thought FS #3 was "burnt out and ... the facility had been short staffed." -she contacted FS #3 to speak to her after she heard about the incident from Client #2's Day Program Administrator. -Client #2 told the day program staff and care coordinator about the allegation of abuse against FS #3. Attempted interviews on 10/26/23 and 10/31/23 with FS #3 were unsuccessful. Voicemail messages were left for FS #3 but the calls were not returned. Interview on 10/26/23 with Client #2's Care Coordinator revealed:	V 512		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL044-036	A. BUILDING: _____ B. WING _____	R 10/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAYWOOD COUNTY GROUP HOME #4	185 FARLEY STREET WAYNESVILLE, NC 28786

(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 512	Continued From page 25 -observed client #2 to have a bruised eyelid and swollen lip on 7/19/23 during a scheduled visit. -Client #2 reported to her that, " 'didn't' want to get anyone in trouble ... [FS #3] had come into the bathroom over the weekend and told her she was acting like a child ... she could send her to a homeless shelter ...and put both hands on her face and pushed her backwards.' " -Client #2 was not scared. -Client #2's "eyelid was blue and lip was swollen." -did not receive a call from facility staff regarding incident with Client #2. -told the facility that they needed to file an IRIS (North Carolina Incident Response Improvement System) report. Interview on 10/30/23 with the QP #2 revealed: -was out of town when the allegation of abuse against FS #3 was reported by Client #2. -"received a call from an outside provider that they were concerned about a bruise on Client #2's face and lip." -there was no GER in Client #2's record regarding bruises or a fall, which she thought was suspicious. -"[FS #3] was asked ...if a GER was done and she told them (management) she did one ...there wasn't one done." -helped complete the IRIS report and Health Care Personnel Registry notification. -watched facility video footage for 20 minutes, "couldn't watch it anymore (because it was too upsetting) and knew that it went on for another 20 minutes." -would look to see if Client #2 had been seen by a medical provider. Interview on 10/30/23 and 10/31/23 with the ED/QP #1 revealed: -got a phone call from the Day Program	V 512		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL044-036	A. BUILDING: _____ B. WING _____	R 10/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAYWOOD COUNTY GROUP HOME #4	185 FARLEY STREET WAYNESVILLE, NC 28786

(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 512	Continued From page 26 Administrator on 7/17/23 that Client #2 had a bruise on her face and abuse allegations against FS #3. -"immediately" had Human Resource (HR) Director review camera footage of the facility from the time frame reported by Client #2. -"had technological difficulties and couldn't access audio footage." - couldn't prove physical abuse because they don't have cameras in the bathroom or bedrooms. -"could see (witness) the verbal abuse later (on camera)." -did not seek medical attention for Client #2 per policy. -FS #3 was terminated on 7/20/23. -the delay in terminating FS #3 was "due to technology." Review on 10/24/23 of the facility's internal investigation notes written by the ED/QP #1 and Human Resources (HR) director revealed: -HR Director was able to review "the living room camera at Farley for 7/14/23 around 1700 hours (5:00PM) with audio and video ...[FS #3] was witnessed using a very elevated tone of voice, cursing, yelling, and making demands of the individual (Client #2) ...demands were for individual (Client #2) to ride her bike for exercise ...the individual told [FS #3] she needed to use the restroom, to which the request was denied ...FS #3 became increasingly belligerent with individual ...cameras verified that [FS #3] was alone with the individual (Client #2)." -"recommended termination for FS #3 ... and to be placed on the Health Care Personnel Registry." Interview on 10/30/23 with the ED/QP #1 revealed:	V 512		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL044-036	A. BUILDING: _____ B. WING _____	R 10/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAYWOOD COUNTY GROUP HOME #4	185 FARLEY STREET WAYNESVILLE, NC 28786

(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 512	Continued From page 27 -couldn't prove physical abuse because the camera footage didn't show inside the bathroom or bedrooms. -"found on video Friday (7/14/23), Client #2 was on her bicycle (stationary) and FS #3 doing her thing ...yelling at her and wouldn't let her get off the bike." -"[FS #3] was saying something like," 'If you'd listen, I wouldn't have to yell so d**n much.'" -"could see the verbal abuse later." -" ...I (ED/QP #1) didn't see a bruise on Client #2 per se." -did not interview Client #2 about what happened. -didn't notify Department of Social Services or Law Enforcement. -did not know if Client #2 received medical treatment. Review on 10/31/23 of email dated 10/31/23 at 8:59AM from the HR Director regarding request to see facility video footage revealed: "due to errors in the video footage, we have very little we could retain ..." Review on 10/31/23 of the Plan of Protection dated 10/31/23 signed by the Qualified Professional #2 (QP #2) revealed: "What immediate action will the facility take to ensure the safety of the consumers in your care? Upon notification of suspected harm, abuse, neglect, or exploitation, the QP, ED (Executive Director), and HR (Human Resources) will convene and immediately remove the staff in question. The QP will work with the coordinator to ensure that the client is seen in a medical facility within 12 hours. The ED and HR director will immediately begin their investigation. The QP will start the IRIS report and submit it within 24 hours. The ED will contact DSS, Law Enforcement, Parent/Guardian, and the Managed	V 512		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL044-036	A. BUILDING: _____ B. WING _____	R 10/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAYWOOD COUNTY GROUP HOME #4	185 FARLEY STREET WAYNESVILLE, NC 28786

(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 512	Continued From page 28 Care Organization (MCO) within 12 hours. The staff member in question will be placed on administrative leave for the length of the investigation. All investigations will be completed within 5 days of the notification. The IRIS report will be completed and uploaded, and parents/guardians will be notified. Appropriate measures will be taken regarding the staff member pending the results of the investigation. Describe your plans to make the above happens: The ED will work with the QP's and HR to make a flow chart of what needs to happen when an allegation is made with a place for initials and date and time for the person completing the task. We will review the ARC of Haywood County Policy (Licensee) #404 at our next staff meeting with the Coordinators where we will show the flow chart." Review on 10/31/23 of the Amended Plan of Protection dated 10/31/23 signed by the Qualified Professional #2 revealed: "Describe your plans to make the above happens: The ED will work with the QP's and HR to make a flow chart of what needs to happen when an allegation of harm, abuse, neglect, or exploitation is made with a place for initials and date and time for the person who completed the task. The ED and QP's will review the ARC of Haywood County Policy (Licensee) #404 (Abuse, Neglect, and Exploitation of Individuals) at our next staff meeting, which will be with Coordinators where we will show the flow chart. Our next staff meeting with ED, QP's, HR and all Coordinators will be on Tuesday, November 7, 2023." This facility serves adult clients with diagnoses including Intellectual and Developmental	V 512		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL044-036	A. BUILDING: _____ B. WING _____	R 10/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAYWOOD COUNTY GROUP HOME #4	185 FARLEY STREET WAYNESVILLE, NC 28786

(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 512	Continued From page 29 Disability, Down Syndrome, Autism, Bipolar Disorder, and Anxiety. Client #2 was brought to the day program on Monday, July 17, 2023, and observed to have a bruised eyelid and lip. Client #2 reported to the day program staff that Former Staff #3 (FS #3) had pushed her that weekend in the bathroom and told (Client #2) that she "could send her to a homeless shelter." FS #3 was observed in video footage restricting Client #2 to an exercise bike and refusing requests for bathroom breaks and cursing at Client #2. The Executive Director/Qualified Professional #1 (ED/QP #1) learned about the allegations on 7/17/23 but failed to put protective measures in place during the investigation into FS #3's alleged abuse of Client #2. FS #3 was allowed to continue to work with clients after receiving the abuse report. FS #3 was terminated on 7/20/23. ED/QP #1 failed to get medical care for Client #2 and failed to document any injuries or interviews with Client #2 thus not fully investigating all allegations or protecting her during their investigation. This deficiency constitutes a Type A1 rule violation for Serious Harm, Abuse, and Neglect and must be corrected within 23 days. An administrative penalty of $ 1,000.00 is imposed. If the violation is not corrected within 23 days, an additional administrative penalty of $500.00 per day will be imposed for each day the facility is out of compliance beyond the 23rd day.	V 512		