STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL060-468	A. BUILDING: ______ B. WING ______	R 10/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE TAYLOR HOME	**5026 LANSING DRIVE CHARLOTTE, NC 28270**

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V 000	INITIAL COMMENTS An annual, complaint, and follow up survey was completed on 10/26/2023. The complaint was unsubstantiated (intake #NC00206073). 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 5. The survey sample consisted of audits of 3 current clients.	V 000		
V 105	27G .0201 (A) (1-7) Governing Body Policies 10A NCAC 27G .0201 GOVERNING BODY POLICIES (a) The governing body responsible for each facility or service shall develop and implement written policies for the following: (1) delegation of management authority for the operation of the facility and services; (2) criteria for admission; (3) criteria for discharge; (4) admission assessments, including: (A) who will perform the assessment; and (B) time frames for completing assessment. (5) client record management, including: (A) persons authorized to document; (B) transporting records; (C) safeguard of records against loss, tampering, defacement or use by unauthorized persons; (D) assurance of record accessibility to authorized users at all times; and (E) assurance of confidentiality of records. (6) screenings, which shall include: (A) an assessment of the individual's presenting problem or need; (B) an assessment of whether or not the facility	V 105		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL060-468	A. BUILDING: ______ B. WING ______	R 10/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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V 105	Continued From page 1	V 105		

can provide services to address the individual's needs; and
(C) the disposition, including referrals and recommendations;
(7) quality assurance and quality improvement activities, including:
(A) composition and activities of a quality assurance and quality improvement committee;
(B) written quality assurance and quality improvement plan;
(C) methods for monitoring and evaluating the quality and appropriateness of client care, including delineation of client outcomes and utilization of services;
(D) professional or clinical supervision, including a requirement that staff who are not qualified professionals and provide direct client services shall be supervised by a qualified professional in that area of service;
(E) strategies for improving client care;
(F) review of staff qualifications and a determination made to grant treatment/habilitation privileges:
(G) review of all fatalities of active clients who were being served in area-operated or contracted residential programs at the time of death;
(H) adoption of standards that assure operational and programmatic performance meeting applicable standards of practice. For this purpose, "applicable standards of practice" means a level of competence established with reference to the prevailing and accepted methods, and the degree of knowledge, skill and care exercised by other practitioners in the field;

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	MHL060-468	A. BUILDING: ______ B. WING ______	R 10/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE TAYLOR HOME	5026 LANSING DRIVE CHARLOTTE, NC 28270

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V 105	Continued From page 2 This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to implement governing body policies to safeguard records against loss. The findings are: Review on 10/05/2023 of the facility's records revealed: -No video surveillance footage of the alleged abuse incident involving Client #1 and Staff #1 dated 08/02/2023. Review on 10/05/2023 of a document titled "[Client #1] Investigation Summary" revealed: -Completed by the Former Program Supervisor. -" ...Video footage did not show [Staff #1], the alleged abuser entering or exiting [Client #1]'s room during the entire duration of the surveillance footage reviewed on the day and date in question of Wednesday 08/02/2023." Interview on 10/18/2023 with the Clinical Supervisor/Former Qualified Professional (QP) revealed: -"Me (Clinical Supervisor/Former QP) and [Former Program Supervisor] looked at it (video of the alleged abuse incident dated 08/02/2023) on that Thursday (08/03/2023). We did not make copies of the video because we did not see evidence of abuse." Interviews on 10/05/2023 and 10/26/2023 with the Program Supervisor revealed: -Did not have the video surveillance footage of the alleged abuse incident involving Client #1 and	V 105		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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V 105	Continued From page 3 Staff #1 dated 08/02/2023. -Would ensure copies of video evidence was retained moving forward. Interview on 10/26/2023 with the Licensee revealed: -"We have processes and procedures in place for instances like this." -Would ensure procedures as it relates to video evidence were followed moving forward.	V 105		
V 112	27G .0205 (C-D) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (c) The plan shall be developed based on the assessment, and in partnership with the client or legally responsible person or both, within 30 days of admission for clients who are expected to receive services beyond 30 days. (d) The plan shall include: (1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement; (2) strategies; (3) staff responsible; (4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both; (5) basis for evaluation or assessment of outcome achievement; and (6) written consent or agreement by the client or responsible party, or a written statement by the provider stating why such consent could not be obtained.	V 112		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL060-468	A. BUILDING: ______ B. WING ______	R 10/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE TAYLOR HOME	**5026 LANSING DRIVE CHARLOTTE, NC 28270**

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V 112	Continued From page 4	V 112		

This Rule is not met as evidenced by:
Based on record reviews, observation and interviews the facility failed to implement treatment strategies to address the needs of clients affecting 1 of 3 audited Clients (#1). The findings are:

Reviews on 10/05/2023 and 10/17/2023 of Client #1's record revealed:
-Admitted 08/12/2022.
-Diagnosed with Moderate Intellectual or Developmental Disability, Schizoaffective Disorder, Bipolar Disorder, Allergic Rhinitis, Gastroesophageal Reflux Disease, Chronic Obstructive Pulmonary Disease, Hypothyroidism, and Hypertension.
-Risk Support Needs Assessment dated 05/08/2023 revealed: "Material and Caregiver Supports: Needs assistance from another person to ambulate. [Client #1] uses her walker for short distances and needs person beside her at all times when using the walker. Needs assistance from another person with transferring. [Client #1] needs assistance to transfer in and out of wheelchair. She can bare weight and walk short distances with support next to her. Walker: [Client #1] will use walker for short distances and always needs person beside her when using the walker ..."
-Treatment plan dated 07/01/2023 revealed: "1) [Client #1] will increase her daily living skills and develop new activities of daily living. 2) [Client

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL060-468	A. BUILDING: ______ B. WING ______	R 10/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE TAYLOR HOME	**5026 LANSING DRIVE CHARLOTTE, NC 28270**

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V 112	Continued From page 5	V 112		

#1] will increase independence and community access skills acquisition. 3) [Client #1] will participate in activities that are meaningful for her in integrated setting with persons who are not disability."

Review on 10/05/2023 of Client #1's facility incident report dated 07/25/2023 revealed:
-Completed by the Program Coordinator.
-"[Client #1] got up and exit the van with the help from staff (Program Coordinator), after [Client #1] exited the van staff asked her to stand and hold the walker so that staff can turn the van off. [Client #1] did not listen to what staff had to say, and [Client #1] turn her back and sit on the walker and fell to the ground. [Client #1] had a bruise on her left hand ..."

Observation on 10/04/2023 between approximately 1:30 pm - 3:30 pm of the facility revealed:
-Client #1 ambulating with the use of a walker without staff by her side.

Observation on 10/25/2023 between approximately 2:30 pm - 4:00 pm of the facility revealed:
-Client #1 ambulating with the use of a walker without staff by her side.

Interview on 10/25/2023 with Client #1 revealed:
-Required the use of a walker to ambulate.
-Staff was not always with her when she used her walker to ambulate.

Interview on 10/25/2023 with Staff #1 revealed:
-Client #1 does not always have staff at her side when she used her walker.

Interview on 10/18/2023 with the Clinical

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL060-468	A. BUILDING: ______ B. WING ______	R 10/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE TAYLOR HOME	**5026 LANSING DRIVE CHARLOTTE, NC 28270**

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V 112	Continued From page 6 Supervisor/Former Qualified Professional revealed: -Was not aware that Client #1's treatment plan required staff to be at her side when she used her walker to ambulate. -"[Client #1] has a 1:1 (staff) in the morning." Interviews on 10/18/2023 and 10/26/2023 with the Program Supervisor revealed: -"I need to check her (Client #1) treatment plan." -Was not aware that Client #1's treatment plan required staff to be at her side when she used her walker to ambulate. -Would ensure implementation of Client #1's treatment plan as required moving forward. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 112		
V 114	27G .0207 Emergency Plans and Supplies 10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES (a) A written fire plan for each facility and area-wide disaster plan shall be developed and shall be approved by the appropriate local authority. (b) The plan shall be made available to all staff and evacuation procedures and routes shall be posted in the facility. (c) Fire and disaster drills in a 24-hour facility shall be held at least quarterly and shall be repeated for each shift. Drills shall be conducted under conditions that simulate fire emergencies. (d) Each facility shall have basic first aid supplies accessible for use.	V 114		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL060-468	A. BUILDING: ______ B. WING ______	R 10/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE TAYLOR HOME	5026 LANSING DRIVE CHARLOTTE, NC 28270

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V 114	Continued From page 7	V 114		

This Rule is not met as evidenced by:
Based on record review and interview the facility failed to ensure fire and disaster drills were completed quarterly for each shift. The findings are:

Review on 10/06/2023 of Fire and Disaster Drill logs from 01/01/2023 - 09/30/2023 revealed:
-First shift (6:00 am - 2:00 pm) and second shift (2:00 pm - 11:00 pm) fire and disaster drills for the First Quarter from 01/01/2023 - 03/30/2023 were completed on the same day and at the exact time; 01/01/2023 at 5:30 am and 02/01/2023 at 10:00 am.
-No time specified for the second shift (2:00 pm - 11:00 pm) disaster drill on 05/30/2023 for the Second Quarter from 04/01/2023 - 06/30/2023.
-No first shift (6:00 am - 2:00 pm) fire drill for 09/2023 in the Third Quarter from 07/01/2023 - 09/30/2023.

Interview on 10/04/2023 with the Program Coordinator revealed:
-First Shift (6:00 am - 2:00 pm), Second Shift (2:00 pm - 11:00 pm), and Third Shift (11:00 pm - 6:00 am).
-Facility completed fire and disaster drills every month.

Interview on 10/18/2023 with the Clinical Supervisor/Former Qualified Professional revealed:
-"Me and [Program Coordinator] were responsible for the oversight of drills (fire and disaster)."
-Fire and disaster drills completed on the same day and at the exact time were documentation errors.

Interview on 10/18/2023 with the Program

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	MHL060-468	A. BUILDING: ______ B. WING ______	R 10/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE TAYLOR HOME	**5026 LANSING DRIVE CHARLOTTE, NC 28270**

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V 114	Continued From page 8 Supervisor revealed: -"You can't run fire and disaster drills at the same time (same day and at the exact time)." -Would ensure completion of fire and disaster drills as required moving forward. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 114		
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 interview and record review, the facility failed to notify Health Care Personnel Registry (HCPR) within 24 hours of learning about allegations of abuse affecting 1 of 3 audited Staff (#1). The findings are: Review on 10/17/2023 of Staff #1's personnel	V 318		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL060-468	A. BUILDING: ______ B. WING ______	R 10/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE TAYLOR HOME	5026 LANSING DRIVE CHARLOTTE, NC 28270

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V 318	Continued From page 9	V 318		

record revealed:
-Hire date of 12/30/2022.
-Job Title of Direct Support Professional.

Review on 10/05/2023 of a document titled "HCPR 24 Hour Initial Report" revealed:
-"Incident Date: 08/04/2023.
-Allegation Description: [Registered Nurse (RN)] contacted Program Supervisor (former Program Supervisor) on 08/04/2023 around 12:30 pm to report that she received an anonymous phone call from a staff reporting that [Client #1] mentioned to her, while in the bathroom getting [Client #1] ready for the day, that another staff [Staff #1] beat her in her back on 8/2/23 in [Client #1] bedroom.
-Accused Individual Information: [Staff #1]."

Review on 10/05/2023 of the facility's records revealed:
-A fax confirmation cover page dated 08/07/2023 addressed to the North Carolina (NC) Division of Health and Human Services with confirmed delivery on 08/10/2023 for a 24 Hour HCPR Report.
-A copy of the above HCPR 24 Hour Initial Report for the allegation of abuse against Staff #1.

Review on 10/05/2023 of the NC Incident Response Improvement System for the facility reports from 07/01/2023-10/03/2023 revealed:
-A Level III incident report for the allegation of abuse made by Client #1 against Staff #1 submitted 08/07/2023.

Interview on 10/04/2023 with the Program Coordinator revealed:
-Incident involving Client #1 and Staff #1 occurred on 08/02/2023.
-Learned of the allegation of abuse made by

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	MHL060-468	A. BUILDING: ______ B. WING ______	R 10/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE TAYLOR HOME	5026 LANSING DRIVE CHARLOTTE, NC 28270

(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 10 Client #1 against Staff #1 on 08/03/2023. -Notified her supervisor (Clinical Supervisor/Former Qualified Professional (QP)) of the allegation of abuse made by Client #1 against Staff #1 on 08/03/2023. Interview on 10/05/2023 with the facility's RN revealed: -Received an anonymous phone call to report the alleged abuse of Client #1 by Staff #1 on 08/03/2023. -Informed the former Program Supervisor of the abuse allegation that Client #1 made against Staff #1 on 08/03/2023. Interview on 10/18/2023 with the Clinical Supervisor/Former QP revealed: -Incident involving Client #1 and Staff #1 occurred on 08/02/2023. -Learned of the allegation of abuse made by Client #1 against Staff #1 on 08/03/2023. -Began the internal investigation of the alleged abuse incident involving Client #1 and Staff #1 on 08/03/2023. -Did not notify HCPR of the allegation against Staff #1 within 24 hours as required. Interview on 10/05/2023 with the Program Supervisor revealed: -The former Program Supervisor did not notify HCPR within 24 hours after becoming aware of the allegation of abuse made against Staff #1 as required. -Would ensure that all allegations made against staff are reported to HCPR within 24 hours moving forward.	V 318		
V 366	27G .0603 Incident Response Requirments	V 366		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL060-468	A. BUILDING: ______ B. WING ______	R 10/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE TAYLOR HOME	5026 LANSING DRIVE CHARLOTTE, NC 28270

(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 11 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 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	V 366		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL060-468	A. BUILDING: ______ B. WING ______	R 10/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE TAYLOR HOME	**5026 LANSING DRIVE CHARLOTTE, NC 28270**

(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 12 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 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	V 366		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL060-468	A. BUILDING: ________ B. WING ________	R **10/26/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE TAYLOR HOME	**5026 LANSING DRIVE CHARLOTTE, NC 28270**

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V 366	Continued From page 13	V 366		

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 records review and interviews, the facility failed to implement written policies governing their response to level I, II, and III incidents. The findings are:

Reviews on 10/04/2023 and 10/05/2023 of the facility records revealed:
No Risk/Cause/Analysis for:
-Client #2's fall incident that required Emergency Medical Technicians (EMTs') assistance dated 07/20/2023.
-Client #1's arm and shoulder fall injury incident that required treatment other than first aid to include pain management at a local medical facility dated 07/30/2023.
-Client #1's suspected abuse allegation made against Staff #1 dated 08/02/2023.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL060-468	A. BUILDING: ______ B. WING ______	R 10/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE TAYLOR HOME	5026 LANSING DRIVE CHARLOTTE, NC 28270

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V 366	Continued From page 14 -Client #1's facial fall injury that required treatment other than first aid to include pain management at a local medical facility dated 10/21/2023. Interviews on 10/18/2023 and 10/26/2023 with the Clinical Supervisor/Former Qualified Professional revealed: -"I was not aware of the process (Risk/Cause/Analysis requirement for level I, II, and III incidents)." -Did not complete the Risk/Cause/Analysis for the incidents dated 07/20/2023, 07/30/2023, 08/02/2023, and 10/21/2023. Interviews on 10/05/2023, 10/18/2023, and 10/26/2023 with the Program Supervisor revealed: -Did not complete or ensure completion of the Risk/Cause/Analysis for the incidents dated 07/20/2023, 07/30/2023, 08/02/2023, and 10/21/2023. -Would ensure completion of the Risk/Cause/Analysis for level I, II, and III incidents moving forward.	V 366		
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	V 367		

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	MHL060-468	A. BUILDING: ______ B. WING ______	R 10/26/2023

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V 367	Continued From page 15	V 367		

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 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

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V 367	Continued From page 16	V 367		

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 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 reviews and interviews, the facility failed to report all level II and III incidents

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	MHL060-468	A. BUILDING: ______ B. WING ______	R 10/26/2023

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THE TAYLOR HOME	5026 LANSING DRIVE CHARLOTTE, NC 28270

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V 367	Continued From page 17	V 367		

in the Incident Response Improvement System (IRIS) and notify the Local Management Entity (LME)/Managed Care Organization (MCO) responsible for the catchment area where services as required. The findings are:

Review on 10/05/2023 of IRIS from 07/01/2023-10/03/2023 revealed:
-A Level III IRIS report for the allegation of abuse made by Client #1 against Staff #1 submitted 08/07/2023.
-No level II IRIS report or LME/MCO notification for Client #1's arm and shoulder fall injury incident that required treatment other than first aid to include pain management at a local medical facility dated 07/30/2023.

Review on 10/25/2023 of IRIS from 10/03/2023-10/25/2023 revealed:
-No level II IRIS report or LME/MCO notification for Client #1's facial fall injury that required treatment other than first aid to include pain management dated 10/21/2023.

Review on 10/05/2023 of an IRIS report for Client #1 submitted 08/07/2023 revealed:
-"Date of incident: 08/04/2023.
-Date Provider learned of the incident: 08/04/2023.
-Physical Abuse.
-08/07/2023 [Registered Nurse (RN)] contacted Program Supervisor (Former Program Supervisor) on 08/04/2023 around the time of 12:30 pm to report that she received an anonymous phone call from a staff reporting that [Client #1] mentioned to her, that another staff [Staff #1] beat her in her back on 08/02/2023 in [Client #1] bedroom."

Interview on 10/04/2023 with the Program

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V 367	Continued From page 18	V 367		

Coordinator revealed:
-Learned of the allegation of abuse made by Client #1 against Staff #1 on 08/03/2023.
-Reported the above allegation to her supervisor (Clinical Supervisor/Former Qualified Professional (QP)) on 08/03/2023.

Interviews on 10/18/2023 and 10/26/2023 with the Clinical Supervisor/Former QP revealed:
-Learned of the allegation of abuse made by Client #1 against Staff #1 on 08/03/2023.
-Began the internal investigation of the alleged abuse incident involving Client #1 and Staff #1 on 08/03/2023.
-Did not submit IRIS reports or LME/MCO notifications for Client #1's arm and shoulder fall injury incident that required treatment other than first aid to include pain management at a local medical facility dated 07/30/2023 or Client #1's facial fall injury that required treatment other than first aid to include pain management at a local medical facility dated 10/21/2023.
-Did not submit the IRIS report for Client #1's alleged staff abuse incident dated 08/02/2023 within 24 hours as required.

Interview on 10/05/2023 with the facility's RN revealed:
-Received an anonymous phone call to report the alleged abuse of Client #1 by Staff #1 on 08/03/2023.
-Informed the former Program Supervisor of the abuse allegation that Client #1 made against Staff #1 on 08/03/2023.

Interviews on 10/05/2023, 10/18/2023, and 10/26/2023 with the Program Supervisor revealed:
-The Former Program Supervisor did not submit the IRIS report for Client #1's alleged staff abuse

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V 367	Continued From page 19 incident dated 08/02/2023 within 24 hours of becoming aware of the incident. -IRIS reports would be submitted as required moving forward.	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 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:	V 500		

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V 500	Continued From page 20 (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 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 records review and interviews, the facility failed to ensure all incidents of alleged abuse are reported to the County Department of Social Services (DSS). The findings are: Review on 10/17/2023 of Staff #1's personnel record revealed: -Hire date of 12/30/2022. -Job Title of Direct Support Professional.	V 500		

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V 500	Continued From page 21 Review on 10/05/2023 of the North Carolina Incident Response Improvement System for the facility reports from 07/01/2023-10/03/2023 revealed: -A Level III incident report for the allegation of abuse made by Client #1 against Staff #1 was submitted on 08/07/2023. -DSS was notified of the above incident on "08/05/2023" and not within 24 hours of the facility becoming aware of the allegation of abuse made against Staff #1. Interview on 10/04/2023 with the Program Coordinator revealed: -Incident involving Client #1 and Staff #1 occurred on 08/02/2023. -Learned of the allegation of abuse made by Client #1 against Staff #1 the day after the incident on 08/03/2023. -Notified her supervisor (Clinical Supervisor/Former Qualified Professional (QP)) of the allegation of abuse made by Client #1 against Staff #1 on 08/03/2023. Interview on 10/18/2023 with the Clinical Supervisor/Former QP revealed: -Incident involving Client #1 and Staff #1 occurred on 08/02/2023. -Learned of the allegation of abuse made by Client #1 against Staff #1 on 08/03/2023. -Began the internal investigation of the alleged abuse incident involving Client #1 and Staff #1 on 08/03/2023. -Did not notify DSS of the allegation of abuse for Staff #1 within 24 hours. Interview on 10/05/2023 with the facility's Registered Nurse revealed: -Received an anonymous phone call to report the	V 500		

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V 500	Continued From page 22 alleged abuse of Client #1 by Staff #1 on 08/03/2023. -Informed the former Program Supervisor of the abuse allegation that Client #1 made against Staff #1 on 08/03/2023. -Did not notify DSS of the allegation of abuse for Staff #1 within 24 hours. Interview on 10/05/2023 with the Program Supervisor revealed: -The former Program Supervisor did not notify DSS within 24 hours after becoming aware of the allegation of abuse made against Staff #1. -Would ensure that all allegations made against staff are reported to DSS within 24 hours moving forward.	V 500		