STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION				(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL012-152		7/0.0005	03	8/08/2024	
NAME OF PF	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE ELMONT DRIVE	, ZIP CODE			
STATES H	OME		NTON, NC 28655				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE	(X5) COMPLET DATE	
V 000	INITIAL COMMENTS	3	V 000				
	An annual and comp on March 8, 2024. Th substantiated (intake Deficiencies were cit	#NC00213838).					
		ed for the following service 27G. 5600F Supervised Family Living.					
	census of 1. The sur	d for 2 and currently has a vey sample consisted of ient and 1 former client.					
V 318	130 .0102 HCPR - 24 Hour Reporting		V 318				
	The reporting by hea Department of all all personnel as defined including injuries of u done within 24 hours becoming aware of the health care facilit	2 INVESTIGATING AND TH CARE PERSONNEL 14th care facilities to the egations against health care 1 in G.S. 131E-256 (a)(1), 10th Inknown source, shall be 5 of the health care facility the allegation. The results of 1y's investigation shall be partment in accordance with					
	failed to notify the He	iew and interview, the facility					

STATEMENT OF DEFICIENCIES     (X1) PROVIDER/SUPPLIER/CLIA       AND PLAN OF CORRECTION     IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			E SURVEY PLETED
		A. BUILDING:			
	MHL012-152	B. WING		03	8/08/2024
ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	ZIP CODE		
OME					
(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLETI DATE
Continued From page	e 1	V 318			
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record revealed: -admission date 9/20 -diagnoses of Mild In Disability, Schizophre Disorder, Diabetes M Hypothyroidism, Hyp	//19. tellectual Developmental enia, Post-Traumatic Stress lellitus Type II, Depression, verlipidemia, Hypertension,				
facility revealed: -a level III physical al involving the AFL pro- -date licensee learne -date licensee initiate -licensee comment 1 claimed after inciden (AFL provider) pushe area." -1/24/24 comment by Entity/Managed Care "2Please complete	buse allegation on 1/8/24 ovider and FC #2. ed of incident 1/9/24. ed incident report 1/22/24. /24/24 "Member (FC #2) t report submission that staff ed her into the kitchen/living / Local Management e Organization comment				
Interview and record Qualified Professiona -the AFL provider cal 1/9/24, after the incid -it was reported that pushed the AFL prov -on 1/9/24 she interv from FC #2 who state	review on 3/7/24 with the al revealed: led her the next morning, dent. FC #2 "attacked" and ider. iewed and typed a statement ed the AFL provider pushed				
	ROVIDER OR SUPPLIER OME SUMMARY S <sup>3</sup> (EACH DEFICIENC REGULATORY OR Continued From pag care personnel within becoming aware of the are: Review on 3/6/24 of record revealed: -admission date 9/20 -diagnoses of Mild In Disability, Schizophri Disorder, Diabetes M Hypothyroidism, Hyp Depression, Esophag Reflux Disease. Review on 3/6/24 of facility revealed: -a level III physical a involving the AFL pro- -date licensee learned -date licensee initiate -licensee comment 1 claimed after incident (AFL provider) pushed area." -1/24/24 comment by Entity/Managed Care "2Please complete completely" -1/24/24 licensee con Interview and record Qualified Professiona -the AFL provider call 1/9/24, after the incid- it was reported that pushed the AFL prov- on 1/9/24 she interv from FC #2 who state her and she fell to th	IDENTIFICATION NUMBER:         IDENTIFICATION NUMBER:         IDENTIFICATION NUMBER:         IDE         MHL012-152         ROVIDER OR SUPPLIER         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         Continued From page 1         care personnel within 24 hours of the facility becoming aware of the allegation. The findings are:         Review on 3/6/24 of Former Client (FC) #2's record revealed: -admission date 9/20/19. -diagnoses of Mild Intellectual Developmental Disability, Schizophrenia, Post-Traumatic Stress Disorder, Diabetes Mellitus Type II, Depression, Hypothyroidism, Hyperlipidemia, Hypertension, Depression, Esophagitis, and Gastroesophageal Reflux Disease.         Review on 3/6/24 of IRIS reports submitted by the facility revealed: -a level III physical abuse allegation on 1/8/24 involving the AFL provider and FC #2. -date licensee learned of incident 1/9/24. -date licensee initiated incident report 1/22/24. -licensee comment 1/24/24 "Member (FC #2) claimed after incident report submission that staff (AFL provider) pushed her into the kitchen/living area." -1/24/24 licensee complete the HCPR section completely" -1/24/24 licensee completed the HCPR portion.         Interview and record review on 3/7/24 with the Qualified Professional revealed: -the AFL provider called her the next morning, 1/9/24, after the incident. -it was reported that FC #2 "attacked" and pushed the AFL provider. -on 1/9/24 she interviewed and typed a statement from FC #2 who stated the AFL provider pushed her and she fell to the ground.	PF CORRECTION       IDENTIFICATION NUMBER:       A. BUILDING:         MHL012-152       B. WING         ROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE,         OME       4320 BELMONT DRIVE MORGANTON, NC 28655         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC DENTIFYING INFORMATION)       ID PREFIX TAG         Continued From page 1       V 318         care personnel within 24 hours of the facility becoming aware of the allegation. The findings are:       V 318         Review on 3/6/24 of Former Client (FC) #2's record revealed:       V 318         -admission date 9/20/19.       -diagnoses of Mild Intellectual Developmental Disability, Schizophrenia, Post-Traumatic Stress Disorder, Diabetes Mellitus Type II, Depression, Hypothyroidism, Hyperlipidemia, Hypertension, Depression, Esophagitis, and Gastroesophageal Reflux Disease.       Review on 3/6/24 of IRIS reports submitted by the facility revealed: - a level III physical abuse allegation on 1/8/24 involving the AFL provider and FC #2. -date licensee initiated incident report 1/22/24. -licensee comment 1/24/24 "Member (FC #2) claimed after incident report submission that staff (AFL provider) pushed her into the kitchen/living area." -1/24/24 comment by Local Management Entity/Managed Care Organization comment "2Please complete the HCPR section completely" -1/24/24 licensee completed the HCPR portion.         Interview and record review on 3/7/24 with the Qualified Professional revealed: -the AFL provider; called her the next morning, 1/9/24, after the incident. -it was reported that FC #2 "attacked" and pushed the AFL provider. -on 1/9/24	OPE CORRECTION       DENTFICATION NUMBER:       A BUILDING:         MHL012-152       B. WING         COVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE         OME       4220 BELMONT DRIVE MORGANTON, NC 28655         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE FRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       D PREVISE         Continued From page 1       V 318         Continued From page 1       V 318         Care personnel within 24 hours of the facility becoming aware of the allegation. The findings are:       V 318         Review on 3/6/24 of Former Client (FC) #2's record revealed:	FCORRECTION       IDENTIFICATION NUMBER       A BUILDING:

STATE FORM

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If continuation sheet 2 of 7

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL012-152	B. WING		03	8/08/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	, ZIP CODE		
STATES H	IOME		LMONT DRIVE NTON, NC 28655			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	COMPLET
V 318	Continued From page	e 2	V 318			
	pushed her putting he	lling. [AFL provider] then er hands on her throat[AFL ing her to her room causing				
	Quality Manager reve -he conducted and ty the "Guardian team O internal investigation. -on 1/9/24 during inter determined this was incident. -as typed on 1/9/24 - [AFL provider] put he #2's) throatI called provider) grabbed my started pushing me (I my room and that is v -he "chose to wait to	ped the interviews found on Contacts" as part of the erviews with FC #2 it was more than a client behavior FC #2's guardian stated " r hands around her (FC [FC #2]"She (AFL / neck(AFL provider) FC #2) and shoving me to				
V 367	10A NCAC 27G .060 REPORTING REQUI CATEGORY A AND E (a) Category A and E level II incidents, exc the provision of billab consumer is on the p incidents and level II to whom the provider 90 days prior to the in responsible for the ca services are provided	REMENTS FOR B PROVIDERS B providers shall report all ept deaths, that occur during ble services or while the roviders premises or level III deaths involving the clients rendered any service within hocident to the LME atchment area where d within 72 hours of he incident. The report shall	V 367			

				(X3) DATE SURVEY COMPLETED		
		MHL012-152	B. WING		03	/08/2024
NAME OF PF	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE	, ZIP CODE		
STATES H	ОМЕ		LMONT DRIVE			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN O		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	THE APPROPRIATE	COMPLETE DATE
V 367	Continued From page	e 3	V 367			
	in person, facsimile o	or encrypted electronic				
	means. The report s	hall include the following				
	information:					
		rovider contact and				
	identification information;					
	<ul> <li>(2) client identification information;</li> <li>(2) type of incident;</li> </ul>					
	<ul><li>(3) type of incident;</li><li>(4) description of incident;</li></ul>					
	(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 th					
		cords including confidential				
	information;					
	(2) reports by c	other authorities; and				
		r's response to the incident.				
		3 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					
		ne incident. Category A				
	providers shall send					
		client death to the Division of				
		lation within 72 hours of				
	-	ne incident. In cases of				

AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		MHL012-152	B. WING		03/08/2024	
NAME OF PI	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE, 2	ZIP CODE		
STATES H	ОМЕ		LMONT DRIVE			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
	Continued From page 4 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					
	been no reportable in incidents have occur meet any of the criter (a) and (d) of this Rul through (4) of this Pa This Rule is not met Based on record revi	t indicating that there have incidents whenever no red during the quarter that ria as set forth in Paragraphs le and Subparagraphs (1) ragraph.				
	Response Improvem	ent System (IRIS) within 72 ware of the incident. The				

				·		E SURVEY PLETED
			A. BUILDING:			
		MHL012-152	B. WING		0	3/08/2024
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	ZIP CODE		
STATES H	ОМЕ		LMONT DRIVE NTON, NC 28655			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 367	Continued From page	e 5	V 367			
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	Qualified Professiona -the AFL provider cal 1/9/24, after the incid -it was reported that pushed the AFL prov -on 1/9/24 she interv from FC #2 who state her and she fell to the -"Carrie's statement angry and started ye pushed her putting he provider] began push [FC #2] to fall" Interview and record Quality Manager reve	led her the next morning, lent. FC #2 "attacked" and ider. iewed and typed a statement ed the AFL provider pushed e ground. When [FC #2] said she got lling. [AFL provider] then er hands on her throat[AFL ning her to her room causing				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION				(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BUILDING:				
		MHL012-152			03	/08/2024	
	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE, ELMONT DRIVE	ZIP CODE			
STATES H	IOME	MORGA	NTON, NC 28655				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE ) THE APPROPRIATE	(X5) COMPLET DATE	
V 367	determined this was incident. -as typed on 1/9/24 - [AFL provider] put he #2's) throatI called provider) grabbed my started pushing me ( my room and that is -he "chose to wait	erviews with FC #2 it was more than a client behavior FC #2's guardian stated " er hands around her (FC [FC #2]"She (AFL y neck(AFL provider) FC #2) and shoving me to	V 367				