Division of Health Service Regulation

			(X3) DATE S COMPL			
		MHL0601538	B. WING		04/17	7/2024
NAME OF	PROVIDER OR SUPPLIER	STREET AC	DRESS, CITY,	STATE, ZIP CODE		
WINGS	GROUP HOME LLC	6346 MOI CHARLO	RNINGVIEW TTE, NC 28	COURT 269		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	DBE	(X5) COMPLETE DATE
V 105	(Intake #NC002114 This facility is licens category: 10A NCAC Living for Minors with the second of the survive second of the sec	was completed on mplaint was substantiated 26). Deficiencies were cited. ed for the following service C 27G .5600B Supervised h Developmental Disability. ed for 3 and currently has a rvey sample consisted of ient. Governing Body Policies Of GOVERNING BODY ody responsible for each all develop and implement he following: hagement authority for the lity and services; sion; rge; sments, including: the assessment; and ompleting assessment. agement, including: ed to document; rds; ords against loss, tampering, y unauthorized persons; ord accessibility to all times; and fidentiality of records.	V 105	RECEIVED MAY 1 3 2021 DHSR-MH-Licensure Sect		

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

STATE FORM

Division of Health Service Regulation
STATEMENT OF DEFICIENCIES 1 (X1) PRO

	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	CONSTRUCTION	COMPLE	
		MHL0601538	B. WING		04/17	/2024
	PROVIDER OR SUPPLIER	6346 MOI	DRESS, CITY, ST RNINGVIEW C TTE, NC 2826	OURT		
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	recommendations; (7) quality assurance activities, including: (A) composition and assurance and qual (B) written quality as improvement plan; (C) methods for mor quality and appropri including delineation utilization of service (D) professional or of a requirement that is professionals and professionals and professionals and professionals and professionals for important that area of service; (E) strategies for important that area of service; (E) strategies for important that area of service; (E) review of staff quality determination made treatment/habilitation (G) review of all fata were being served in residential programs (H) adoption of standards purpose, "applicable standards purpose, "applicable means a level of correference to the prevented of the prevent	e and quality improvement d activities of a quality ity improvement committee; ssurance and quality nitoring and evaluating the ateness of client care, n of client outcomes and s; dinical supervision, including staff who are not qualified rovide direct client services by a qualified professional in proving client care; alifications and a to grant	V 105			
	OFSEFFICEREGERATION (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SUR	VEY
TE FORM		08	99 CYZ	311	continuation she	of 77 of 7

	of Health Service Re	gulation			TORWIALTIK	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	G:	COMPLETED	
			B. WING			
		MHL0601538			04/17/202	24
	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	, STATE, ZIP CODE		
WINGS	GROUP HOME LLC	6346 MOF CHARLO	RNINGVIEV TTE, NC 28	V COURT 8269		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMP	X5) IPLETE ATE
	This Rule is not me Based on record revealed: Review on 03/19/20 record revealed: -Admitted 12/05/2 -Discharged 12/27 -Diagnosed with A Moderate Intellect Hyperactivity, Vita Oppositional Defia -No written discha Interview on 03/22/2 Guardian revealed: -"They (facility) did in notice. She (License Professional (QP)) juto come back (to the Interview on 03/19/20 revealed: -FC #1 was discharg was hospitalized for -The facility issued a FC #1 prior to his 12 -Was not able to loca notice"Hopefully, [QP] can	t as evidenced by: view and interviews, the elop and implement written ures for discharge. The 24 of Former Client (FC) #1's 23. 7/2023. Autism Spectrum Disorder, ual Disorder, Attention Deficit min D Deficiency, and ant Disorder. rge notice. 024 with the FC #1's and give a written discharge are (L)/Owner (O)/Qualified ust said she did not want him a facility)." 024 with the L/O/QP ed on 12/27/2023 after he behaviors. written discharge notice for		Followed Discharge policy per 560 Service Definition. And NCDHHS for discharge. Verbal conversation occurred on December 12, 2023, to initiate Discharge for FC with Care Coordinator. Initial Email was ser Care Coordinator on December 12, 2023, to state that agency is official requesting Discharge for FC. The Discharge form was completed and emailed to Care Coordinator on Discharge was also completed in Uinch Concall that occurred on 12/29/2022 Care Coordinator staff, FC guardin No Bounds Care, Inc. staff; Care Coordinator asked if we would be to take client back until he turned old on Jan 17, 2024, so she could plan 18. AFL? And I replied, "Yes" FC Mobegan yelling and requesting refundays that FC was not in home and "I do not want him back there" Copies of correspondence (emails between CC and NBC Staff) regardinitiation of Discharge from No Bocare facility was provided during so QP who processed discharge was not in home was not also the processed discharge was not care facility was provided during so QP who processed discharge was not care facility was provided during so QP who processed discharge was not care facility was provided during so QP who processed discharge was not care facility was provided during so QP who processed discharge was not care facility was provided during so QP who processed discharge was not care facility was provided during so QP who processed discharge was not care facility was provided during so QP who processed discharge was not care facility was provided during so QP who processed discharge was not care facility was provided during so QP who processed discharge was not care facility was provided during so QP who processed discharge was not care facility was provided during so QP who processed discharge was not care facility was provided during so QP who processed discharge was not care facility was provided during so QP who processed discharge was not care facility was provided during so QP who	Rule on ore ot to 2, dlly d dec 14, 2023, M. dian and willing 18 yrs lace in om d for stated ding unds survey. ot	
	notice)."	you need (discharge		available when unannounced surve occurred.	У	
		024 with FC #1's with the		Discharge (Attached) blank		
	OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION (>	(3) DATE SURVEY	The Decision of the

Division of Health Service Regulation AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: COMPLETED B. WING MHL0601538 04/17/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE WINGS GROUP HOME LLC 6346 MORNINGVIEW COURT CHARLOTTE, NC 28269 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5)PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) V 105 Continued From page 3 V 105 facility's Transitions Coordinator (TC) revealed: Care Coordinator "never" stated "this -FC #1 was discharged on 12/27/2023 after he was his first incident was not enough for was hospitalized for behaviors. an emergency discharge." -The facility did not issue a written discharge notice for FC #1. L/O/QP stated on call with other team -"We (TC and FC #1's Care Coordinator) members, CC and guardian "we will discussed with her (L/O/QP) that she needed to allow FC to return and remain in the give a notice (discharge) and that his first incident home" until he is ready to be placed in was not enough for an emergency discharge." AFL. Interview on 04/03/2024 with the QP revealed: -FC #1 was discharged on 12/27/2023. Mom was upset and requested a refund -Was not able to locate a copy of FC #1's written for unused days, hung up when I called discharge notice. her in Japan to notify her that hospital needed her to call to provide Consent for V 108 27G .0202 (F-I) Personnel Requirements V 108 treatment. And on call on 12/29/2023 stated "I do not want FC to go back to 10A NCAC 27G .0202 PERSONNEL No Bounds" so Care Coordinator REQUIREMENTS proceeded with emergency Discharge. (f) Continuing education shall be documented. (g) Employee training programs shall be Discharge copy was mailed to Care provided and, at a minimum, shall consist of the Coordinator and her staff was cc'd following: (1) general organizational orientation: (2) training on client rights and confidentiality as Admin will review all discharge delineated in 10A NCAC 27C, 27D, 27E, 27F and paperwork immediately to check behind 10A NCAC 26B: OP supervisor for accuracy and to (3) training to meet the mh/dd/sa needs of the ascertain receipt of recipient. client as specified in the treatment/habilitation plan; and (4) training in infectious diseases and bloodborne pathogens. (h) Except as permitted under 10a NCAC 27G .5602(b) of this Subchapter, at least one staff member shall be available in the facility at all times when a client is present. That staff member shall be trained in basic first aid including seizure management, currently trained to provide cardiopulmonary resuscitation and STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY .. AND PLAN OF CORRECTION Ulatio **IDENTIFICATION NUMBER:** COMPLETED

Division	of Health Service R	egulation				MITTOVEL
			A. BUILDING	G:		
		MHL0601538	B. WING		04/	17/2024
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
WINGS	GROUP HOME LLC	6346 MOF CHARLO	RNINGVIEW TTE, NC 28	V COURT 3269		
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V 108	trained in the Heim techniques such as the American Hear equivalence for reli (i) The governing be implement policies reporting, investiga	lich maneuver or other first aid those provided by Red Cross, the Association or their eving airway obstruction. The and procedures for identifying, ting and controlling infectious diseases of personnel and	V 108	No Bounds Care Inc Shall ascert staff working residential program be trained in Cardiopulmonary Resuscitation CPR and basic firs including seizure management, F TO HIRE	n shall t aid	
	facility failed to ens trained in Cardiopul and First Aid and 3 were trained in seiz findings are: Review on 03/19/20 record revealed: -Hire date 12/17/202-No trainings in CPF Management. Review on 03/19/20 record revealed: -Hire date 12/18/202-No training in Seizu Review on 03/19/20 record revealed: -Hire date 10/05/202-No training in Seizu Interview on 03/19/2	views and interviews, the ure 1 of 1 Staff (#1) was monary Resuscitation (CPR) of 3 Staff (#1, #2, and #3) ure management. The 24 of Staff #1's personnel 23. 24 of Staff #2's personnel 23. 24 of Staff #2's personnel 23. 24 of Staff #3's personnel 25. 26 re Management. 27 of Staff #3's personnel 28 of Staff #3's personnel 29 of Staff #3's personnel 20 of Staff #3's personnel 21 of Staff #3's personnel 22 of Staff #3's personnel 23 of Staff #3's personnel 24 of Staff #3's personnel		Staff #1 – stated that he had com CPR -First Aid and Seizure Man training prior to hire with another agency and was awaiting copy to to No Bounds for file. Staff #1 (No longer Employed) Staff #2 completed Seizure Mana Training (on file). Staff #3 – was verified that he had completed CPR training prior to with another agency and staff had presented copy for file with No Boundary Care. Admin will review all HR files evidays to check behind QP supervisaccuracy and completion of all retrainings. Policy Procedure update 5/3/24	agement er provide gement d hire d not ounds ery 30- er for quired	
AND PLAN C	OF DEFICIENCIES OF CORRECTION Of the Correct Control of the Correct	IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION	(X3) DATE SU COMPLE	

(X3) DATE SURVEY

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FORM APPROVED Division of Health Service Regulation B. WING MHL0601538 04/17/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE WINGS GROUP HOME LLC 6346 MORNINGVIEW COURT CHARLOTTE, NC 28269 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) PRFFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) V 108 Continued From page 5 V 108 Licensee/Owner/Qualified Professional revealed: L/O/QP response to question was -Staff #1 did not complete CPR/First Aid training. misstated and in reference to current -Staff #1, Staff #2, and Staff #3 did not complete Policy for other services that are Seizure Management training. provided by agency which allow -"Our policy says they (staff) will be trained in 30 CPR/First Aid Training.to be completed days (from date of hire)." within first 30-days "after" Hire. V 109 27G .0203 Privileging/Training Professionals V 109 Effective immediately All staff with residential program shall have trainings 10A NCAC 27G .0203 COMPETENCIES OF 'prior to Hire" and if trainings have QUALIFIED PROFESSIONALS AND occurred with another agency prior to ASSOCIATE PROFESSIONALS (a) There shall be no privileging requirements for hire; staff shall present copy of qualified professionals or associate professionals. CPR/First Aid and Seizure Management (b) Qualified professionals and associate Training prior to hire to for file. professionals shall demonstrate knowledge, skills and abilities required by the population served. Staff # 1 stated that he had completed (c) At such time as a competency-based CPR/First Aid and Seizure Management employment system is established by rulemaking, training with another agency prior to then qualified professionals and associate hire with NBC and was waiting to professionals shall demonstrate competence. present copy for file. (d) Competence shall be demonstrated by exhibiting core skills including: technical knowledge; Staff #1 No longer employed. (2) cultural awareness; (3) analytical skills: Staff #2 completed CPR/First Aid and (4) decision-making; Seizure Management training prior to (5) interpersonal skills: hire (filed) (6) communication skills; and (7) clinical skills. Admin will review all HR files every 30-(e) Qualified professionals as specified in 10A days to check behind QP supervisor for NCAC 27G .0104 (18)(a) are deemed to have accuracy and completion of all required met the requirements of the competency-based employment system in the State Plan for trainings. Policy Procedure updated MH/DD/SAS. 5/3/24 (f) The governing body for each facility shall develop and implement policies and procedures for the initiation of an individualized supervision

STATE FORM CYZ311 If continuation sheet 27 of 27

A. BUILDING:

(X2) MULTIPLE CONSTRUCTION

plan upon hiring each associate professional.

(X1) PROVIDER/SUPPLIER/CLIA

IDENTIFICATION NUMBER:

STATEMENT OF DEFICIENCIES

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AND PLAN OF CORRECTION

Division of Health Service Regulation

MHL0601538 B. WING 04/17/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE WINGS GROUP HOME LLC 6346 MORNINGVIEW COURT CHARLOTTE, NC 28269 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRFFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE **PREFIX** TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) V 109 Continued From page 6 V 109 Staff #2 HCPR pulled prior to Hire (g) The associate professional shall be (filed) supervised by a qualified professional with the population served for the period of time as L/O/OP specified in Rule .0104 of this Subchapter. Over 12 yrs experience with Admin Dayto-Day Operations, scheduling training for staff, preparing Discharges (notification of Discharge 1st occurred Dec 12th, 2023 and written notice followed on Dec 13th), and ascertain that at least 1 staff on each shift were trained in This Rule is not met as evidenced by: Medication Management. Based on record reviews and interviews, 1 of 2 Qualified Professionals (Licensee (L)/Owner Staff #1 stated that he had received (O)/Qualified Professional (QP)) failed to Medication Management and demonstrate the knowledge, skills and abilities Alternatives to restrictive interventions required by the population served. The findings and seclusion, physical restraint and isolation with another agency prior to Review on 04/03/2024 of the L/O/QP's record hire and had requested copy of revealed: certificate to provide copy to NBC). -Hire date: 01/04/2022. -Education: Bachelor's in business administration Staff # 1 No longer employed. (2003) and Master's in Counseling (May 2013). Staff #2 HCPR pulled, reviewed and filed Interview on 03/19/2024 with the L/O/QP prior to hire. revealed. -"I oversee the day to day operations of the facility." Staff #2 scheduled to complete -Was responsible for accessing HCPR for staff Medication Management and prior to hire but did not access HCPR for Staff #2. Alternatives to restrictive interventions -Was responsible for issuing written discharge and seclusion, physical restraint and notices for clients but did not issue a written isolation training, rescheduled due to was notice for Former Client (FC) #1. not able to do on scheduled date. -Was responsible for ensuring staff were trained in medication administration but did not ensure No Bounds Care QP Supervisor shall that Staff #1 and Staff #2 were trained. ascertain that "all" staff are trained in -Was responsible for ensuring staff were trained in alternatives to restrictive interventions and Medication Management and NCI prior seclusion, physical restraint, and isolation to hire moving forward. Admin will review all HR files every 30days to check behind QP supervisor for accuracy and completion of all required alth Service Regulation

CYZ311

trainings.	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SU	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: COMPLET	TED
MHL0601538 B. WING 04/17/2	2024
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS. CITY, STATE, ZIP CODE	
WINGS GROUP HOME LLC 6346 MORNINGVIEW COURT	
CHARLOTTE, NC 28269	
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DEFICIENCY)	
V 109 Continued From page 7 V 109	
time-out but did not ensure that Staff #1 and Staff	
#2 were trained. Did not travel to hospital on 12/27/2023	
-Was responsible for ensuring that FC #1 was because Care Coordinator who was	
supervised 24 hours per day/7 days per week but did allow FC #1 to travel the hospital with medics incident and said she would go to hospital	
unottended and then allowed him to remain at the	
hospital unattended on 12/27/2023	
contact with mom and coordinate with	
V 118 27G .0209 (C) Medication Requirements V 118 hospital staff to coordinate services for FC	
10A NCAC 27G .0209 MEDICATION	
REQUIREMENTS Effective immediately When FC(s) are	
(c) Medication administration: transported for care, staff shall follow	
(1) Prescription or non-prescription drugs shall EMS to hospital to make sure check and	
only be administered to a client on the written or discharged from care	
order of a person authorized by law to prescribe	
drugs. If staff on duty is unable to follow	
(2) Medications shall be self-administered by	
clients only when authorized in writing by the client's physician. Will be contacted to fill in. Policy Providers and 5/3/24	
(3) Medications, including injections, shall be	
administered only by licensed persons, or by	
unlicensed persons trained by a registered nurse,	
pharmacist or other legally qualified person and	
privileged to prepare and administer medications.	
(4) A Medication Administration Record (MAR) of	
all drugs administered to each client must be kept	
current. Medications administered shall be recorded immediately after administration. The	
MAR is to include the following:	
(A) client's name;	
(B) name, strength, and quantity of the drug;	
(C) instructions for administering the drug;	
(D) date and time the drug is administered; and	
(E) name or initials of person administering the	

Division	n of Health Service Re	egulation				
	drug.					
		for medication changes or				
		orded and kept with the MAR				
	file followed up by	appointment or consultation				
STATEME	INT OF DEFICIENCIES	(V1) PROVIDED/CLIPDLIED/CLIA	(V2) MULTIF	DI E CONSTRUCTION	(VO) DATE	OUDVEV
	N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE COMP	LETED
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NAME OF	NAME OF PROVIDER OR SUPPLIER STREET A		DRESS, CITY,	STATE, ZIP CODE		
WINGS	GROUP HOME LLC	6346 MQI	RNINGVIEW	COURT		
		CHARLO	TTE, NC 28	3269		
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V 118	Continued From page	ge 8	V 118			V.
	with a physician.					
				Staff #1 stated that he had receive	d	
	This Rule is not me			Medication Management and		
		and record review, the facility		Alternatives to restrictive interver	itions	
		f received training in		and seclusion, physical restraint a		
		tration completed by a		isolation training with another a		
		narmacist, or other legally		prior to hire and had requested		
	The findings are:	ecting 2 of 3 Staff (#1 and #2).		of certificate to provide copy to		
	The illiumgs are.			NBC).	,	
	Review on 03/19/20	24 of Staff #1's personnel		NBC).		
	record revealed:	24 of otali #1 3 personner		CA CC II A N. A		1
	-Hire date 12/17/202	23		Staff # 1 No longer employed.		
	-No Medication Adm					
		3.		Staff #2 scheduled to complete		
	Review on 03/19/20.	24 of Staff #2's personnel		Medication Management and	gr.	- 1
	record revealed:	Company of the Compan		Alternatives to restrictive interven		- 1
	-Hire date 12/18/202	23.		and seclusion, physical restraint, a		- 1
	-No Medication Adm	inistration training.		isolation training, rescheduled due	to was	- 1
	127 (S) 2 100 (S) 200 (S)			not able to do on scheduled date.		
	Interview on 03/19/2					
		alified Professional revealed:				
	-Staff #1 and Staff #:			L/O/QP response to questions rega	irding	
	Medication Administ			MM training was in reference to c		
		ey (staff) will be trained in 30		Policy for other services that are		
	days (from date of h	ire).		provided by agency which allow		
17.50	0.0 1015			Medication Training to be complete	ed	
V 131	G.S. 131E-256 (D2) Verification	HCPR - Prior Employment		within first 30-days "upon" Hire.		

Division of Health Service Regulation					FURIVI	APPROVED
	G.S. §131E-256 HEALTH CARE PERSONNEL REGISTRY (d2) Before hiring health care personnel into a			Effective immediately No Bounds QP Supervisor shall ascertain the staff are trained in Medication Management prior to hire. Admin will review all HR files ev days to check behind QP supervis accuracy and completion of all re trainings. Policy Procedure upday 5/3/24	ery 30- sor for	
	NT OF DEFICIENCIES NOF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION S:	(X3) DATE COMP	SURVEY LETED
		MHL0601538	B. WING		04/1	7/2024
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY.	STATE, ZIP CODE		
WINGS	GROUP HOME LLC	6346 MOF CHARLO	RNINGVIEW TTE, NC 28	COURT 269		
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V 131	health care facility s Personnel Registry	ge 9 r service, every employer at a shall access the Health Care and shall note each incident propriate business files.	V 131			
	facility failed to acce affecting 1 of 3 staff Review on 03/19/202 record revealed: -Hire date 12/18/202 -No HCPR accessed Interview on 03/19/2 Licensee/Owner/Qua-Was responsible for staff prior to hire.	views and interviews, the ss the HCPR prior to hire (#2). The findings are: 24 of Staff #2's personnel 3.		Staff # 2 HCPR pulled and filed phire. Effective immediately No Bounds (QP Supervisor shall ascertain that staff are trained in HCPR prior to Admin will review all HR files ever days to check behind QP supervisor accuracy and completion of all requirainings.	Care "all" hire.	

Division	of Health Service R	egulation				
	Staff #2.				86.0	
1	-"I have to check o	n the HCPR (for Staff #2)."				
V 290	o		V 290			
1 20	27G .5602 Supervi	ised Living - Staff	V 250			
	- Cooc Caponi	Joseph Stan				
	10A NCAC 27G .5	602 STAFF				1
	(a) Staff-client ratios above the minimum numbers specified in Paragraphs (b), (c) and (d) of this Rule shall be determined by the facility to enable staff to respond to individualized client					
1						
			1			
	needs.					
1	(b) A minimum of a	one staff member shall be				
	present at all times	when any adult client is on the				
	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	S:	COMP	LETED
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WINGS	GROUP HOME LLC		RNINGVIEW			
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V 290	Continued From pa	ge 10	V 290			
	nremises excent w	hen the client's treatment or				
		cuments that the client is				
	conchlo of remaining	currients that the client is				
	capable of remaining	ng in the home or community				
	without supervision	. The plan shall be reviewed				
	as needed but not i	ess than annually to ensure				
	the client continues	to be capable of remaining in				
		unity without supervision for				
	specified periods of	time.				
	(c) Staff shall be pre	esent in a facility in the				
	following client-staff	ratios when more than one				
	child or adolescent	client is present:			1	
	(1) children or	r adolescents with substance				- 1
	abuse disorders sha	all be served with a minimum				1
	of one staff present	for every five or fewer minor				1
		wever, only one staff need be				- 1
		ping hours if specified by the				- 1
		procedures determined by				- 1
	the governing body;					- 1
		adolescents with				- 1
	, ,					
		pilities shall be served with				
		every one to three clients	i			
	present and two stat	ff present for every four or				
		t. However, only one staff				
	need be present dur	ring sleeping hours if				- 1
1	specified by the eme	rgency back-up procedures				- 1
	determined by the g					- 1
	alth Service Regulation	,				- 1

Division	of Health Service R	egulation ch serve clients whose primary				, ,
	diagnosis is substance abuse dependency: (1) at least one staff member who is on duty shall be trained in alcohol and other drug withdrawal symptoms and symptoms of secondary complications to alcohol and other drug addiction; and (2) the services of a certified substance abuse counselor shall be available on an as-needed basis for each client.					
	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE COMP	SURVEY
				1		
		MHL0601538	B. WING		04/1	7/2024
	PROVIDER OR SUPPLIER GROUP HOME LLC		DRESS, CITY, RNINGVIEW	STATE, ZIP CODE		
		CHARLO	TTE, NC 28	269		
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETE DATE
V 290	Continued From pa	ge 11	V 290			
	facility failed to ensulabilitation plan doccapable of remainin supervision for spectreviewed annually at (FC #2). The finding Review on 03/19/20 revealed: -Admitted 12/05/202-Discharged 12/27/2-Diagnosed with Aut Moderate Intellectual Hyperactivity, BVitar D Deficiency, and Op-Treatment plan date documentation for uncommunity.	views and interviews, the are a clients' treatment or sumented the client was g in the community without sified periods of time and affecting 1 of 1 Former Clients are: 24 of FC #1's record 3. 023. ism Spectrum Disorder, I Disorder, Attention Deficit min oppositional Defiant Disorder. ed 12/05/2023 provided no insupervised time in the		Did not travel to hospital on 12/27/because Care Coordinator who wa involved via phone call during entificident said she would go to hospital follow-up with FC while I make cowith mom and coordinate with hose staff to coordinate services for FC. Communicated with ER staff over 24 hrs to assist with coordination of Effective immediately and ongoing resident are transported to hospital	ire ital to intact spital next of care.	

Division of Health Service Regulation						
		hospital unsupervised by staff		care; Staff on duty will follow FO		
	on 12/27/2023.			hospital to make sure resident is		
	-"the medics said	id we (facility staff) did not need		in and or discharged. Policy Proc		
	to go to the hospita	al."		updated 5/3/24		
	Interview on 03/19/	1/2024 with the				
		Qualified Professional revealed:				
		ported by local medics and				
		hospital unsupervised by staff				
	on 12/27/2023.	moopital alloupe, field 2, 21				
	The state of the s	did not go to the hospital (with			1	
		23) but was in contact with the			,	
	hospital. I was not	told to go to the hospital with			1	
	him."	,				
	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	10.00	8		PLETED
		1	1		1	
		MHL0601538	B. WING	_	04/1	7/2024
	The second of the second secon				U -, ,,	112024
	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
WINGS	GROUP HOME LLC	6346 MOR CHARLO7	RNINGVIEW TTE, NC 282	COURT		
			IE, NO LOS	209		
(X4) ID		ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP		COMPLETE DATE
			Reportus.	DEFICIENCY)		
V 366	27G .0603 Incident	Response Requirements	V 366			ĺ
	1	Tresponse requirements	V 555			i
	10A NCAC 27G .0	0603 INCIDENT	/			
	RESPONSE REQU		J			
	CATEGORY A AND	D B PROVIDERS		ĺ		1
		B providers shall develop and	J	İ		
		policies governing their	ļ	i		
		Il or III incidents. The policies		l .		
		ovider to respond by:		l .		
	(1) attending t	to the health and safety needs	J	į.		
	of individuals involve (2) determining	ng the cause of the incident;				
		ing the cause of the incident;				
		g to provider specified				
	timeframes not to ex					
		g and implementing measures				
		icidents according to provider				
	specified timeframes	es not to exceed 45 days;				
	(5) assigning	person(s) to be responsible				
		of the corrections and				
	preventive measures					
		to confidentiality requirements				
		Article 2A, 10A NCAC 26B,				
		3 and 45 CFR Parts 160 and				
	164; and (7) maintaining	ng documentation regarding				-
		1) through (a)(6) of this Rule.				
vicion of Hh	Anthan add abiliar and	i) unough (a)(b) or uno ruio.				

Division of Health Service Regulation (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: STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIP	LE CONSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	1000	·		PLETED
		MHL0601538	B. WING		04/1	7/2024
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY,	STATE, ZIP CODE		
WINGS	GROUP HOME LLC	6346 MOR CHARLO	RNINGVIEW TTE, NC 28:	COURT 269		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
V 366	by: (A) obtaining (B) making a (C) certifying (D) transferring review team; (2) convening review team within a internal review team who were not involved were not responsible with direct professions services at the time review team shall confollows: (A) review the determine the facts and make recommended occurrence of future (B) gather oth (C) issue writte within five working of preliminary findings LME in whose catch	ely securing the client record the client record; photocopy; the copy's completeness; and g the copy to an internal 24 hours of the incident. The n shall consist of individuals yed in the incident and who e for the client's direct care or onal oversight of the client's of the incident. The internal complete all of the activities as copy of the client record to and causes of the incident andations for minimizing the	V 366			

DIVISIO	n of Health Service Re					
		nal written report signed by the				
		months of the incident. The				
		e sent to the LME in whose				
		e provider is located and to the				
		ent resides, if different. The	1			
		shall address the issues				
	identified by the int	ternal review team, shall	1			
		ocuments pertinent to the				
		make recommendations for				
	minimizing the occ	urrence of future incidents. If				
	all documents need	ded for the report are not	1			
	available within thre	ee months of the incident, the				
STATEME	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		3:		LETED
				· · · · · · · · · · · · · · · · · · ·		
			D MINIC			
		MHL0601538	B. WING		04/1	7/2024
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
WINGS	GROUP HOME LLC	6346 MOF	RNINGVIEW	COURT		
		CHARLO	TTE, NC 28	269		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)
PREFIX		MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD) BE	COMPLETE
TAG	REGULATORY OR LS	REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE		RIATE	DATE	
				DEFICIENCY)		
V 366	Continued From pa	ge 14	V 366			
	I ME may give the n	rovidos on outonoion of to				
		provider an extension of up to				
		omit the final report; and				
		ely notifying the following:				
		esponsible for the catchment				
		rices are provided pursuant to				
	Rule .0604;			20		
	(B) the LME v	where the client resides, if				
	different;					
		ler agency with responsibility				
		updating the client's				
		fferent from the reporting				
	provider;					
	(D) the Depart					
		s legal guardian, as				
	applicable; and					
	(F) any other a	authorities required by law.				
		- SF				i
		1				
	This Rule is not me	t as evidenced by:				
		view and interviews, the				1
		ement written policies		RCA completed		
	• footbo	•		Ongoing Aggressive behaviors with	nessed	- 1

ivision of Hoalth Sorvice Regulation

_	Division ogoverning their response to Level II incidents.					1 OI W	711 1 110 VED
		The findings are: Review on 03/19/2024 of the facility's incident reports from 12/05/2023 - 12/31/2023 revealed: -No Risk/Cause/Analysis (RCA) for: 12/27/2023- Former Client #1's alleged aggressive behaviors that required involvement of local law enforcement, paramedics, and psychiatric hospitalization incident. Interview on 03/19/2024 with the Licensee/Owner/Qualified Professional revealed: -Did not complete the RCA for FC #1's alleged			by Law Enforcement, staff and I resulted in psychiatric hospitaliz And evident by Wall trim was right away from wall and busted after struck it in presence of law enfor FC also ran toward staff after kitall heater with such force that he a hole in and knocked heater into lamp that busted up also.	ation. pped FC reement. cking 2ft e busted o floor	
AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA			G:	(X3) DATE COMP			
			MHL0601538	B. WING		04/1	7/2024
	NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY	STATE, ZIP CODE		
	WINGS	GROUP HOME LLC	6346 MOR	RNINGVIEW TTE, NC 28	COURT		
	(X4) ID PREFIX TAG			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	Continued From page 15				
		A 366 Continued From page 15 aggressive behaviors that required involvement of local law enforcement, paramedics, and psychiatric hospitalization on 12/27/2023.					
	V 367		Reporting Requirements	V 367			
		10A NCAC 27G .					
		REPORTING REQU CATEGORY A AND			22		
			B providers shall report all				
			cept deaths, that occur during lible services or while the				
		consumer is on the	providers premises or level III				
			I deaths involving the clients er rendered any service within				
		90 days prior to the	incident to the LME				
			catchment area where ed within 72 hours of				
		becoming aware of t	the incident. The report shall				
		be submitted on a for Secretary. The repo	orm provided by the ort may be submitted via mail,				
		in person, facsimile	or encrypted electronic				
		means. The report s information:	shall include the following				
			rovider contact and				1
		identification informa (2) client ident	ation; ification information;				
		(Z) CHELLIGER	moanon miornation,				1

CYZ311

If continuation sheet 27 of 27

Division of Health Ser	vice Re	gulation				VIAITROVED
(4) de (5) sta cause of the (6) oth or respondir (b) Categor missing or ir shall submit report recipie day wheney	 (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 		(X2) M.H.TID	LE CONSTRUCTION		
AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	70 10-03 000 000 000 000 000	:		E SURVEY IPLETED
		MHL0601538	B. WING		04	/17/2024
NAME OF PROVIDER OR SU	PPLIER	STREET AD	DRESS CITY	STATE, ZIP CODE		
WINGS GROUP HOME	LLC	6346 MOF	RNINGVIEW TTE, NC 28:	COURT		
PREFIX (EACH DEFI	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY)	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETE DATE
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 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		V 367				

Division	n of Health Service Re		H		I OIN	AFFROVEL
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						
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1000 10	PLE CONSTRUCTION G:	(X3) DATE COMPI	SURVEY	
		MHL0601538	B. WING		04/1	7/2024
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY.	STATE, ZIP CODE		
WINGS	GROUP HOME LLC	6346 MOR CHARLOT	RNINGVIEW TTE, NC 28	COURT 269		
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
	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 incidents 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:			IRIS report completed 12/28/2023 submission failed. Resubmitted and confirmed subm Date was on document before filing Effectively immediately QP Supervisive trained all current staff on he completely submit Incident Report	nission g. visor ow to	
vision of Ho:	alth Service Regulation			with "Submission Date" displayed	on top	

STATE FORM 6899 CYZ311 If continuation sheet 27 of 27

sion of Hoalth Sorvice Regulation

Division	1 of Nhebetheldel Riberra	legationME/MCO notification				MITTOVEL
for: 12/27/2023- Former Client (FC) #1's alleged aggressive behaviors that required involvement of local law enforcement, paramedics, and psychiatric hospitalization incident. Interview on 03/19/2024 with the Licensee/Owner/Qualified Professional revealed: -"I did an IRIS report for him (FC #1)." -Was not aware that the IRIS for FC #1 incident dated 12/27/2023 was not submitted.			right corner of page. Policy Procedure 5/3/24	updated		
	NT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1000 00	LE CONSTRUCTION	(X3) DATE COMP	SURVEY
		MHL0601538	B. WING		04/1	17/2024
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, §	STATE, ZIP CODE		
	GROUP HOME LLC	CHARLOT	RNINGVIEW (TTE, NC 282	269		
(X4) ID PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
V 536	Continued From page	ige 18	V 536			
V 536 27E .0107 Client Rights - Training on Alt to Rest. Int. 10A NCAC 27E .0107 TRAINING ON ALTERNATIVES TO RESTRICTIVE INTERVENTIONS (a) Facilities shall implement policies and practices that emphasize the use of alternatives to restrictive interventions. (b) Prior to providing services to people with disabilities, staff including service providers, employees, students or volunteers, shall demonstrate competence by successfully completing training in communication skills and other strategies for creating an environment in which the likelihood of imminent danger of abuse or injury to a person with disabilities or others or property damage is prevented. (c) Provider agencies shall establish training based on state competencies, monitor for internal compliance and demonstrate they acted on data gathered. (d) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable		V 536				

sion of Health Service Regulation

Division	Division of 14 data Service Reigelations ing or failing the					
	course.					
		er training must be completed				
		ovider periodically (minimum				
	annually).					
	(f) Content of the t	training that the service				
	provider wishes to employ must be approved by					
	the Division of MH/	/DD/SAS pursuant to				
	Paragraph (g) of th					
	(g) Staff shall dem	onstrate competence in the				
	following core area					
		ge and understanding of the				
	people being serve	ed;				
	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
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		MHL0601538	B. WING		04/4	7/2024
		WII 12000 1338			04/1	7/2024
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
WINGS	GROUP HOME LLC	6346 MOF	RNINGVIEW	COURT		
		CHARLO	TTE, NC 282	269		
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL		COMPLETE
TAG REGULATORY OR LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROF DEFICIENCY)	RIATE	DATE	
14.500	6 11 1=					
V 536	Continued From page	ge 19	V 536			
	(2) recognizir	ng and interpreting human				
	behavior;	5 Promig				
		ng the effect of internal and				
		hat may affect people with				
	disabilities;	nat may affect people with				
	1 22 1900 AND THE RESIDENCE OF THE PARTY OF	for building positive				
	, ,	ersons with disabilities;				
		ng cultural, environmental and				
		rs that may affect people with				
	disabilities;	is that may affect people with				
		ig the importance of and				
	, ,	on's involvement in making				
	decisions about their	ir life	1			
		sessing individual risk for				
	escalating behavior;					- 1
		ation strategies for defusing				1
		otentially dangerous behavior;				1
	and	and addigorous bond vior,				- 1
		havioral supports (providing				ı
		ith disabilities to choose				
		ctly oppose or replace				
	behaviors which are					1
	(h) Service provider					- 1
		tial and refresher training for				
	at least three years.					
		ation shall include:				-
	, ,	pated in the training and the				
	alth Service Regulation	pace and the				

Division of Health Service R					
outcomes (pass/fail); (B) when and where they attended; and (C) instructor's name; (2) The Division of MH/DD/SAS may review/request this documentation at any time. (i) Instructor Qualifications and Training Requirements: (1) Trainers shall demonstrate competence by scoring 100% on testing in a training program aimed at preventing, reducing and eliminating the need for restrictive interventions. (2) Trainers shall demonstrate competence		(Y2) MI II TIDI	E CONSTRUCTION	Lyopate	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		N 50		(X3) DATE COMP	LETED
	MHL0601538	B. WING	· · · · · · · · · · · · · · · · · · ·	04/1	7/2024
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
WINGS GROUP HOME LLC	6346 MOR CHARLO	RNINGVIEW (TTE, NC 282	COURT		
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	RRECTIVE ACTION SHOULD BE ERENCED TO THE APPROPRIATE	
V 536 Continued From pa by scoring a passing	ge 20 g grade on testing in an	V 536			
instructor training p					
competency-based	, include measurable learning able testing (written and by				
observation of beha	vior) on those objectives and ds to determine passing or				
failing the course.					
service provider pla	nt of the instructor training the ns to employ shall be				
to Subparagraph (i)					1
shall include but are	e instructor training programs not limited to presentation of:				
(B) methods f	ding the adult learner; or teaching content of the				
	or evaluating trainee				
	ation procedures.				
teaching a training p	nall have coached experience program aimed at preventing,				
interventions at leas	ating the need for restrictive t one time, with positive				
review by the coach (7) Trainers sh	nall teach a training program				
vicion of Health Service Regulation					

Division		equestioning and eliminating the				
		interventions at least once				
	annually.					
		shall complete a refresher				
		at least every two years.				
	(j) Service providers shall maintain documentation of initial and refresher instructor					
	training for at least					
		mentation shall include:				
		cipated in the training and the				
	outcomes (pass/fai					
	(B) when and	d where attended; and				
	(C) instructor	r's name.				
	NT OF DEFICIENCIES NOF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE	
ANDELAN	OF CORRECTION	IDENTIFICATION NOWIDER.	A. BUILDING	S:	COMP	LETED
		MHL0601538	B. WING		04/1	7/2024
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
WINGS	GROUP HOME LLC		RNINGVIEW	AND		
		CHARLO	TTE, NC 28	269		
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	N	(X5)
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD	DBE	COMPLETE	
IAG	TAG REGULATORY OR LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROP DEFICIENCY)	RIATE	DATE
V 526	Cartinuad Facus na	0.1	17.500		-	
V 536	Continued From page	ge 21	V 536			
		ion of MH/DD/SAS may				
		this documentation any time.				
	(k) Qualifications of					
		shall meet all preparation				
	requirements as a ti	And the second s				
		shall teach at least three times				
	the course which is (3) Coaches s	shall demonstrate				
		ipletion of coaching or				
	train-the-trainer inst					
		shall be the same preparation				
	as for trainers.	Patrices and the second second				
	i					
	This Rule is not met	t as evidenced by:		Staff #1 stated that he had received	d	
		view and interview, the facility		Alternatives to restrictive interven	itions	
		f were trained in initial		with another agency prior to hire :	and	
		rictive Interventions affecting		had requested copy of certificate to	0	
	2 of 2 staff (#1, #2).	The findings are:	1	provide copy to NBC).		
			1			- 1

Service Regulation

Division	n of Health Service Re					
DIVISION	Review on 03/19/2024 of Staff #1's personnel record revealed: -Hire date 12/17/2023No initial training in Alternatives to Restrictive Interventions. Review on 03/19/2024 of Staff #2's personnel record revealed: -Hire date 12/18/2023.			Staff # 1 No longer employed. Staff #2 scheduled to complete Alternatives to restrictive trainin rescheduled due to was not able t scheduled date.		
		n Alternatives to Restrictive				
	NT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	12.000 (0.	PLE CONSTRUCTION	(X3) DATE	SURVEY
A116	or connection.	IDENTIFICATION TOMOSE.	A. BUILDING	S:	COIVII .	LEIED
.,		MHL0601538	B. WING		04/1	17/2024
	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
WINGS	GROUP HOME LLC	CHARLO	RNINGVIEW TTE, NC 282	COURT 269		
(X4) ID PREFIX TAG	(EACH DEFICIENCY I	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		DBE	(X5) COMPLETE DATE	
V 536	Continued From page	ge 22	V 536			
	Licensee/Owner/Qualified Professional revealed: -Staff #1 and Staff #2 did not complete initial training in Alternatives to Restrictive InterventionStaff #1 and Staff #2 worked alone with Former Client #1"Our policy says they (staff) will be trained in 30 days (from date of hire)."			Effective immediately all staff will trained in Alternative to Restrictive to the Interventions prior to hire		
V 537	27E .0108 Client Rig ITO	ghts - Training in Sec Rest &	V 537			
10A NCAC 27E .0108 TRAINING IN SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT (a) Seclusion, physical restraint and isolation time-out may be employed only by staff who have been trained and have demonstrated competence in the proper use of and alternatives to these procedures. Facilities shall ensure that staff authorized to employ and terminate these procedures are retrained and have demonstrated competence at least annually. (b) Prior to providing direct care to people with disabilities whose treatment/habilitation plan includes restrictive interventions, staff including service providers, employees, students or volunteers shall complete training in the use of						

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seclusion, physical restraint and isolation time-out and shall not use these interventions until the training is completed and competence is demonstrated. (c) A pre-requisite for taking this training is demonstrating competence by completion of training in preventing, reducing and eliminating the need for restrictive interventions. (d) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable						
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	000 10000000000000000000000000000000000	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		MHL0601538	B. WING		04/1	7/2024
NAME OF E	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
WINGS	GROUP HOME LLC	6346 MOR CHARLO	RNINGVIEW TTE, NC 282	COURT 269		
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V 537	Continued From pa	ge 23	V 537			
ivicion of Ho	methods to determine passing or failing the course. (e) Formal refresher training must be completed by each service provider periodically (minimum annually). (f) Content of the training that the service provider plans to employ must be approved by the Division of MH/DD/SAS pursuant to Paragraph (g) of this Rule. (g) Acceptable training programs shall include, but are not limited to, presentation of: (1) refresher information on alternatives to the use of restrictive interventions; (2) guidelines on when to intervene (understanding imminent danger to self and others); (3) emphasis on safety and respect for the rights and dignity of all persons involved (using concepts of least restrictive interventions and incremental steps in an intervention); (4) strategies for the safe implementation of restrictive interventions; (5) the use of emergency safety interventions which include continuous assessment and monitoring of the physical and psychological well-being of the client and the safe					

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(6) prohibited procedures; (7) debriefing strategies, including their importance and purpose; and (8) documentation methods/procedures. (h) Service providers shall maintain documentation of initial and refresher training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcomes (pass/fail); (B) when and where they attended; and		(X2) MUI TIP	E CONSTRUCTION	(X3) DATE	SLIDVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					PLETED	
		MHL0601538	B. WING		04/	17/2024
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		***
WINGS	GROUP HOME LLC		RNINGVIEW TTE, NC 282			
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V 537	review/request this (i) Instructor Qualific Requirements: (1) Trainers s by scoring 100% or aimed at preventing need for restrictive (2) Trainers s by scoring 100% or teaching the use of and isolation time-o (3) Trainers s by scoring a passing instructor training proceeding the use of an action of the proceeding the training proceeding the course. (5) The content of the proceeding the course. (5) The content of the proceeding the provider plant approved by the Divito Subparagraph (j) of the proceeding the course of the proceeding the proceedin	Is name. Is name. Is name. Is name. Is no of MH/DD/SAS may documentation at any time. Is action and Training hall demonstrate competence in testing in a training program in reducing and eliminating the interventions. hall demonstrate competence in testing in a training program seclusion, physical restraint ut. hall demonstrate competence in grade on testing in an an arrogram. In grade on testing in an arrogram. In grade in testing in an arrogram. In grade on testing in an arrogram in the include measurable learning able testing (written and by vior) on those objectives and is to determine passing or ant of the instructor training the instructor of MH/DD/SAS pursuant	V 537			

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shall include, but not be limited to, presentation of: (A) understanding the adult learner; (B) methods for teaching content of the course; (C) evaluation of trainee performance; and (D) documentation procedures. (7) Trainers shall be retrained at least annually and demonstrate competence in the use of seclusion, physical restraint and isolation time-out, as specified in Paragraph (a) of this Rule.						
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			A. BUILDING	LE CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		MHL0601538	B. WING		04/1	7/2024
WINGS GROUP HOME LLC 6346 MOR			DRESS, CITY, S RNINGVIEW TTE, NC 282	STATE, ZIP CODE COURT 269		
(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
∨ 537	(8) Trainers so CPR. (9) Trainers so in teaching the use least two times with coach. (10) Trainers so use of restrictive into annually. (11) Trainers so instructor training at (k) Service provided documentation of intraining for at least to (1) Document (A) who particulation outcome (pass/fail); (B) when and (C) instructor's (2) The Division review/request this counce (1) Qualifications of (1) Coaches so requirements as a to (2) Coaches so times, the course with the course	shall be currently trained in shall have coached experience of restrictive interventions at happositive review by the shall teach a program on the terventions at least once shall complete a refresher at least every two years. Pers shall maintain initial and refresher instructor three years. Intation shall include: Dipated in the training and the strength of the shall maintain of MH/DD/SAS may documentation at any time. To Coaches: Shall meet all preparation	V 537			

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Division of Health Service Regulation competence by completion of coaching or train-the-trainer instruction. (m) Documentation shall be the same preparation as for trainers. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure staff were trained in initial STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING MHL0601538 04/17/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6346 MORNINGVIEW COURT CHARLOTTE, NC 28269 WINGS GROUP HOME LLC SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX **PREFIX** CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) V 537 V 537 Continued From page 26 Staff #1 stated that he had received seclusion, physical restraint, and isolation Seclusion, Physical Restraint, and time-out affecting 2 of 2 staff (#1, #2). The Isolation Time-Out. with another agency findings are: prior to hire and had requested copy of Review on 03/19/2024 of Staff #1's personnel certificate to provide copy to NBC). record revealed: -Hire date 12/17/2023. Staff # 1 No longer employed. -No initial training in Seclusion, Physical Restraint, and Isolation Time-Out. Review on 03/19/2024 of Staff #2's personnel Staff #2 scheduled to get Seclusion, record revealed: Physical Restraint, and Isolation -Hire date 12/18/2023. Time-Out. -No initial training in Seclusion, Physical Restraint, and Isolation Time-Out. L/O/QP response to questions regarding 03/19/2024 Interview with the on Seclusion, Physical Restraint and Licensee/Owner/Qualified Professional revealed: Isolation Time-Out training was in -Staff #1 and Staff #2 did not complete initial reference to current Policy for other training in Seclusion, Physical Restraint, and services that are provided by agency Isolation Time-Out. which allow this training to be -Staff #1 and Staff #2 worked alone with Former completed within first 30-days "upon" Client #1. -"Our policy says they (staff) will be trained in 30 Hire. days (from date of hire)." Effectively immediately QP Supervisor

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	22.2	PLE CONSTRUCTION 3:	(X3) DATE SI COMPLE	
		MHL0601538	B. WING		04/	17/2024
	PROVIDER OR SUPPLIER	6346 MOF	DRESS, CITY, RNINGVIEW TTE, NC 28			
(X4) ID PREFIX TAG	(EACH DEFICIENCY I	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	O BE	(X5) COMPLETE DATE
V 537	seclusion, physical time-out affecting 2 findings are: Review on 03/19/20 record revealed: -Hire date 12/17/202-No initial training in Restraint, and Isola Review on 03/19/20 record revealed: -Hire date 12/18/202-No initial training in Restraint, and Isola Interview on Licensee/Owner/Qu-Staff #1 and Staff # training in Seclusion Isolation Time-OutStaff #1 and Staff # Client #1.	restraint, and isolation of 2 staff (#1, #2). The 24 of Staff #1's personnel 23. Seclusion, Physical tion Time-Out. 24 of Staff #2's personnel 23. Seclusion, Physical tion Time-Out. 03/19/2024 with the alified Professional revealed: 22 did not complete initial 1, Physical Restraint, and 22 worked alone with Former 29 (staff) will be trained in 30	V 537	Staff #1 stated that he had received Seclusion, Physical Restraint, and Isolation Time-Out. with another prior to hire and had requested occertificate to provide copy to NBC Staff #1 No longer employed. Staff #2 scheduled to get Seclusion Physical Restraint, and Isolation Time-Out. L/O/QP response to questions reg Seclusion, Physical Restraint and Isolation Time-Out training was in reference to current Policy for oth services that are provided by agent which allow this training to be completed within first 30-days "up Hire. Effectively immediately QP Super Have ascertain that all staff have received Seclusion, Physical Restrand Isolation Time Out prior to his if they state that they have received training prior to hire with NBC the need to provide proof prior to hire before working alone with resident Policy Procedure updated 5/3/2024	agency opy of C). on, on arding n ner ncy pon" evisor aint, ire and d iey will e and	
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