| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
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| mhl067-049 | | B. WING | | 08/2 | 2/2024 | |
| NAME OF F | PROVIDER OR SUPPLIER | | | STATE, ZIP CODE | | |
| CAPE CO | DD | | DORIS AVE VILLE, NC | | | |
| (X4) ID | SUMMARY STA | TEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF CORRECTION | ON | (X5) |
| PREFIX TAG | | MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | PREFIX TAG | (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | D BE | COMPLETE DATE |
| V 000 | INITIAL COMMENT | rs | V 000 | | | |
| | 20024. The compla | was completed on August 22, ints were substantiated IC0022313. A deficiency was | | | | |
| | This facility is licensed for the following service category: 10A NCAC 27G.5600C Supervised Living for Adults with Developmental Disabilities. This facility is licensed for 3 and has a current census of 3. The survey sample consisted of audits of 2 current clients. | | | | | |
| | | | | | | |
| V 109 | 109 27G .0203 Privileging/Training Professionals | | V 109 | | | |
| | 10A NCAC 27G .0203 COMPETENCIES OF QUALIFIED PROFESSIONALS AND ASSOCIATE PROFESSIONALS (a) There shall be no privileging requirements for qualified professionals or associate professionals. (b) Qualified professionals and associate professionals shall demonstrate knowledge, skills and abilities required by the population served. (c) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence. (d) Competence shall be demonstrated by exhibiting core skills including: (1) technical knowledge; (2) cultural awareness; (3) analytical skills; (4) decision-making; (5) interpersonal skills; (6) communication skills; and (7) clinical skills. (e) Qualified professionals as specified in 10A NCAC 27G .0104 (18)(a) are deemed to have met the requirements of the competency-based | | | | | |

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

(X6) DATE TITLE

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | | (X3) DATE SURVEY COMPLETED | |
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| mhl067-049 | | B. WING | | 08/ | 08/22/2024 | | |
| | | | DDRESS, CITY, S | | | | |
| CAPE C | OD | | NVILLE, NC 2 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY) | N SHOULD BE E APPROPRIATE | (X5) COMPLETE DATE | |
| V 109 | employment systen MH/DD/SAS. (f) The governing because of the initiation of a plan upon hiring each (g) The associate propulation served for the initiation of a plan upon hiring each (g) the associate propulation served for the initiation of the | ge 1 n in the State Plan for body for each facility shall nent policies and procedures an individualized supervision ch associate professional. professional shall be alified professional with the or the period of time as 104 of this Subchapter. | V 109 | | | | |
| | This Rule is not met as evidenced by: Based on record review and interviews, 1 of 1 Qualified Professional (QP) failed to demonstrate the knowledge, skills and abilities required by the population served. The findings are: Review on 8/14/24 of the QP's personnel file revealed: -Hire date of 11/26/07Job title of QP. Review on 8/14/24 of a North Carolina Incident Response Improvement System (IRIS) report for client #2 revealed: -Date of incident 7/27/24Physical Abuse: "7/30/2024 DA expressed that staff hit him on the face." -Supervisor Actions: "Describe the cause of this incident: At this time, there is no plausible cause for the alleged incident." -Incident Prevention: "7/30/2024 The staff the allegation made against is no longer employed with the agency at his own volition. Current | | | | | | |

Division of Health Service Regulation

STATE FORM 5899 ZGTI11 If continuation sheet 2 of 6

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | | (X3) DATE SURVEY COMPLETED | |
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| | | mhl067-049 | B. WING | | 08/ | 22/2024 |
| CAPE COD 202 EAST | | | DRESS, CITY, S DORIS AVEI | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY | ON SHOULD BE HE APPROPRIATE | (X5) COMPLETE DATE |
| V 109 | employees will receincident reporting tireceive supervision refresher crisis prevalled incident reporting tireceive supervision refresher crisis prevalled incident reperson who conductured in a conducture resident reports and resident re | eive in-service training on mes. Staff will continue to from QP and will complete vention training within 1 week." esult in injury/harm: No." r Staff (FS) #5. acted investigation QP. acted investigation is acted investigation in QP. acted into acted into acted into acted into acted into acted into acted in QP. acted in QP. acted into acted in QP. acted into acted in QP. acted into acted in | V 109 | | | |

Division of Health Service Regulation

STATE FORM 5899 ZGTI11 If continuation sheet 3 of 6

PRINTED: 08/27/2024 FORM APPROVED

Division of Health Service Regulation

| Division of Health Service Regulation | | | | | | |
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| | | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPL | E CONSTRUCTION | (X3) DATE SURVEY | |
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| | | mhl067-049 | B. WING | | 08/2 | 22/2024 |
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| NAME OF I | PROVIDER OR SUPPLIER | | | STATE, ZIP CODE | | |
| CAPE CO | OD | | DORIS AVE | | | |
| | | JACKSON | NVILLE, NC | 28540 | | |
| (X4) ID | | TEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF CORRECTION COR | | (X5) |
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| 1710 | | , | 17.0 | DEFICIENCY) | | |
| V 109 | Continued From pa | 2 | V 109 | | | |
| V 103 | • | | V 103 | | | |
| | | P first spoke with [Client #2]. | | | | |
| | | kplain what happened this | | | | |
| | | ined that Staff 1 (FS #5) "hurt | | | | |
| | | ked to clarify, he stated that | | | | |
| | | ed his hands on his neck and | | | | |
| | | nit him. QP asked if he | | | | |
| | | it happened. He could not | | | | |
| | | ffirmed that I happened when | | | | |
| | | kfast at the table. Following | | | | |
| | my conversation with [Client #2], I examined his facial region for observable injuries. Examination | | | | | |
| | | | | | | |
| | | ns of injury/harm. Following | | | | |
| | | Client #2], QP spoke with | | | | |
| | | QP instructed Client 2 (Client | | | | |
| | | her the events that happened. | | | | |
| | | stated that Staff 1 (FS #5) | | | | |
| | | n the face. He stated the | | | | |
| | | over the weekend during | | | | |
| | | sked to identify precipitating ne incident, Client 2 (Client #3) | | | | |
| | | etails, but continued to state | | | | |
| | • | ing struck by Staff 1 (FS #5). | | | | |
| | | at he had reported this to Staff | | | | |
| | | d Staff 1 (FS #5) that morning. | | | | |
| | | both members, I took the time | | | | |
| | | f member. I requested that he | | | | |
| | | etails of any incidents that | | | | |
| | | veekend when he worked. He | | | | |
| | | incident, I expressed to him | | | | |
| | | f abuse was made against | | | | |
| | | he did not strike. Per the staff | | | | |
| | | e event that happened that | | | | |
| | | that [Client #2] was at the | | | | |
| | | breakfast. He observed | | | | |
| | | food on the floor from not | | | | |
| | | y to the table. He explained | | | | |
| | | osition [Client #2] closer to the | | | | |
| | | dropping food on the floor | | | | |
| | | ated that [Client #2] began to | | | | |
| | | nd that at the point, he | | | | |

Division of Health Service Regulation STATE FORM

| DIVISION | of Health Service Re | egulation | | | | |
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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED | | |
| | | mhl067-049 | B. WING | | 08/2 | 2/2024 |
| NAME OF | PROVIDER OR SUPPLIER | STREET ADI | DRESS, CITY, § | STATE, ZIP CODE | | |
| CAPE C | DD | | DORIS AVE | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | Y MUST BE PRECEDED BY FULL | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | D BE | (X5) COMPLETE DATE |
| V 109 | • | | V 109 | | | |
| | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | | | | |

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Interview on 8/14/24 FS #5 stated:

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED | | |
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| mhl067-049 | | B. WING | | 08/22/2024 | | |
| NAME OF F | PROVIDER OR SUPPLIER | STREET ADI | DRESS, CITY, S | STATE, ZIP CODE | | |
| CAPE CO | DD . | | DORIS AVE | | | |
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| V 109 | Continued From pa | ge 5 | V 109 | | | |
| | -He no longer works -He never hit client Interview on 8/14/24 | #2. 4 Program Manager stated: | | | | |
| | -She had worked at the facility for 16 yearsClient #3 told her FS #5 hit Client #2 three timesShe notified the QP of the allegation against FS #5. | | | | | |
| | -She was notified by about an allegation -She investigated the Client #2 said FS # -Client #3 said FS # -Client #3 said FS # -FS #5 denied hittine -She never checked any injuriesClient #2 had a his allegationsShe said she shound neckFS #5 never came -She completed incompleted incompleted. | the facility since 2018. y the Program Manager in July against FS #5. he allegation against FS #5. #5 grabbed him by the neck. #5 hit Client #2 three times. g Client #2. d Client #2's neck or back for tory of making false Id have checked Client #2's | | | | |
| | | | | | | |

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