STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0921007	A. BUILDING: _____ B. WING _____	08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABC CARE LP	228 GAIL RIDGE LANE WENDELL, NC 27591

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 000	INITIAL COMMENTS A complaint survey was completed on 8/28/24. The complaint was unsubstantiated (intake #NC00219034). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600A Supervised Living for Adults with Mental Illness. This facility is licensed for 6 and has a current census of 5. The survey sample consisted of audits of 2 current clients.	V 000		
V 109	27G .0203 Privileging/Training Professionals 10A NCAC 27G .0203 COMPETENCIES OF QUALIFIED PROFESSIONALS AND ASSOCIATE PROFESSIONALS (a) There shall be no privileging requirements for qualified professionals or associate professionals. (b) Qualified professionals and associate professionals shall demonstrate knowledge, skills and abilities required by the population served. (c) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence. (d) Competence shall be demonstrated by exhibiting core skills including: (1) technical knowledge; (2) cultural awareness; (3) analytical skills; (4) decision-making; (5) interpersonal skills; (6) communication skills; and (7) clinical skills. (e) Qualified professionals as specified in 10A NCAC 27G .0104 (18)(a) are deemed to have met the requirements of the competency-based employment system in the State Plan for	V 109		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0921007	A. BUILDING: _____ B. WING _____	08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABC CARE LP	228 GAIL RIDGE LANE WENDELL, NC 27591

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 109	Continued From page 1 MH/DD/SAS. (f) The governing body for each facility shall develop and implement policies and procedures for the initiation of an individualized supervision plan upon hiring each associate professional. (g) The associate professional shall be supervised by a qualified professional with the population served for the period of time as specified in Rule .0104 of this Subchapter. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to maintain employment of a Qualified Professional (QP). The findings are: Review on 8/19/24 of the QP's personnel record revealed: - Signed QP Job Description with no date Interview on 8/20/24 staff #2 reported: - Had worked at the facility since March of 2024 - Was "not familiar with" the QP Interview on 8/27/24 the former QP reported: - Worked at the facility from "sometime in March" 2024 to 6/28/24 - The Licensee terminated her employment on 6/28/24 - The House Manager reached out to her on 8/23/24 to ask her to be the QP for the facility again but she declined Multiple attempts to reach the QP via telephone	V 109		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0921007	A. BUILDING: _____ B. WING _____	08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABC CARE LP	228 GAIL RIDGE LANE WENDELL, NC 27591

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 109	Continued From page 2 calls and text messages between 8/19/24 and 8/23/24 were unsuccessful Interview on 8/27/24 the QP reported: - Began working for the facility on 8/4/24 - "Was told" staff #2 and the Licensee completed admission paperwork for client #1 - Had lost her phone and did not receive attempted calls and messages from 8/19/24 to 8/23/24 Interview on 8/19/24 the House Manager reported: - Worked at the facility for "less than a month" - The QP had been at the facility twice since he began working there - Did not know who the QP was before he started Interview on 8/27/24 the Licensee reported: - The House Manager had been working at the facility since 6/28/24 - The former QP was terminated from the facility on 6/28/24 - The House Manager hired a new QP after he began working at the facility - Did not know when the new QP began working at the facility	V 109		
V 110	27G .0204 Training/Supervision Paraprofessionals 10A NCAC 27G .0204 COMPETENCIES AND SUPERVISION OF PARAPROFESSIONALS (a) There shall be no privileging requirements for paraprofessionals. (b) Paraprofessionals shall be supervised by an associate professional or by a qualified professional as specified in Rule .0104 of this	V 110		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0921007	A. BUILDING: _____ B. WING _____	08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABC CARE LP	228 GAIL RIDGE LANE WENDELL, NC 27591

(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 110	Continued From page 3 Subchapter. (c) Paraprofessionals shall demonstrate knowledge, skills and abilities required by the population served. (d) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence. (e) 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. (f) The governing body for each facility shall develop and implement policies and procedures for the initiation of the individualized supervision plan upon hiring each paraprofessional. This Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure 1 of 1 audited paraprofessional staff (#1) demonstrated knowledge, skills and abilities required by the population served. The findings are: Review on 8/19/24 of staff #1's record revealed: - Job Title: Certified Nursing Assistant - Hire Date: 7/29/24 Review on 8/19/24 of client #1's record revealed:	V 110		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0921007	A. BUILDING: _____ B. WING _____	08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABC CARE LP	228 GAIL RIDGE LANE WENDELL, NC 27591

(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 110	Continued From page 4 - Admitted: 7/8/24 - Diagnoses: Schizophrenia, History of Traumatic Brain Injury, Hyperlipidemia, Back Pain - Internal report from staff #1 dated 8/15/24: "[Client #1] was not in his room, he left in the middle of the night. He left his belongings behind. I put a call to his sister (guardian/sister #1) who asked me to relax. She assured me that she will get back to me that [client #1] had early phone that he want to leave the facility. She said he will come back. So on 9:00AM of 8/16/24, I called 911 to report his absence." Interview on 8/19/24 client #1 reported: - Had been living at the facility for one month - "Left the other night...when they (staff #1) went to bed" Interview on 8/20/24 client #1's guardian/sister #1 reported: - She spoke with client #1 on the telephone on 8/15/24 around 7:30am - Client #1 told her on the telephone that he was going to "pack some clothes" and leave the facility - Client #1 eloped from the facility on 8/15/24 around 8:00am - Staff #1 called about 8:30am to notify her that client #1 had eloped from the facility - She told staff #1 not to call the police about client #1 eloping from the facility because he was "not missing" and it "wasn't worth it to call" - Staff #1 called the police the morning of 8/16/24 to report client #1 missing - Client #1 arrived to sister #2's home on 8/16/24 at 9:00am - The police called her at 10:47am on 8/16/24 to notify her that client #1 was reported missing - The police went to see client #1 at sister #2's home to verify his well-being	V 110		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0921007	A. BUILDING: _____ B. WING _____	08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABC CARE LP	228 GAIL RIDGE LANE WENDELL, NC 27591

(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 110	Continued From page 5 - Client #1 lived in an independent living apartment for 4 years prior to moving to the facility - Client #1 often became paranoid and thought people were "trying to do something to him" - Client #1 "got upset a few days before he left" Interview on 8/19/24 staff #1 reported: - Been working at the facility for 19 days - The House Manager informed her when she began working at the facility that client #1 "is a wanderer" - Awoke around 6:00am on 8/15/24 and noticed that client #1 was not at the facility - After client #1 did not return within 2 hours, she contacted the House Manager - The House Manager instructed her to contact the police and report client #1 missing - Called client #1's guardian/sister #1 to notify her that client #1 had eloped from the facility - Client #1's guardian/sister #1 informed her that client #1 had called her around 7:30am and told her that he was leaving the facility - Client #1's guardian/sister #1 asked her not to call the police because client #1 "usually leaves and will come back" on his own - She did not call the police because client #1's guardian/sister #1 requested she not call - The House Manager called the morning of 8/16/24 to follow-up about client #1's elopement - Staff #1 notified the House Manager that client #1 had not returned and she had not called the police - The House Manager instructed staff #1 again to call the police and report client #1 missing - Staff #1 called the police at 9:00am on 8/16/24 and the police came to the facility to get information for client #1 - The police called client #1's guardian/sister #1 after getting information from staff #1 and	V 110		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0921007	A. BUILDING: _____ B. WING _____	08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABC CARE LP	228 GAIL RIDGE LANE WENDELL, NC 27591

(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 110	Continued From page 6 client #1's guardian told the police that client #1 "was not missing" and that he was with sister #2 - Client #1's guardian/sister #1 returned him to the facility on 8/16/24 Interview on 8/19/24 the House Manager reported: - Staff #1 called him on 8/15/24 to notify him that client #1 had eloped from the facility - Told staff #1 to call the police if client #1 did not return to the facility within 2 hours - The facility policy stated "when someone walks off, wait about two hours to see if they come back, drive around and look for them, if they don't show up, then call the police" - The House Manager contacted client #1's guardian/sister #1 and she "said don't call the police, they would look for him" and "she would call police" - Followed up with staff #1 on 8/16/24 about client #1 and was notified that client #1 was still absent from the facility - Staff #1 contacted the police and reported client #1 missing the morning of 8/16/24 - "Not a good idea to wait a day" to contact the police - Clients were not given unsupervised time during their first month at the facility Interview on 8/19/24 the Licensee reported: - She was aware of client #1 eloping from the facility on 8/16/24 - The House Manager was responsible for "running the home"	V 110		
V 111	27G .0205 (A-B) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND	V 111		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0921007	A. BUILDING: _____ B. WING _____	08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABC CARE LP	228 GAIL RIDGE LANE WENDELL, NC 27591

(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 111	Continued From page 7 TREATMENT/HABILITATION OR SERVICE PLAN (a) An assessment shall be completed for a client, according to governing body policy, prior to the delivery of services, and shall include, but not be limited to: (1) the client's presenting problem; (2) the client's needs and strengths; (3) a provisional or admitting diagnosis with an established diagnosis determined within 30 days of admission, except that a client admitted to a detoxification or other 24-hour medical program shall have an established diagnosis upon admission; (4) a pertinent social, family, and medical history; and (5) evaluations or assessments, such as psychiatric, substance abuse, medical, and vocational, as appropriate to the client's needs. (b) When services are provided prior to the establishment and implementation of the treatment/habilitation or service plan, hereafter referred to as the "plan," strategies to address the client's presenting problem shall be documented. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure an admission assessment for 1 of 2 audited clients (#1) was completed prior to	V 111		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0921007	A. BUILDING: _____ B. WING _____	08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABC CARE LP	228 GAIL RIDGE LANE WENDELL, NC 27591

(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 111	Continued From page 8	V 111		

delivery of services. The findings are:

Review on 8/19/24 of client #1's record revealed:
- Admitted: 7/8/24
- Diagnoses: Schizophrenia, History of Traumatic Brain Injury, Hyperlipidemia, Back Pain
- No admission assessment which documented the following information:
  - Presenting Problems
  - Needs and strengths
  - Admitting diagnosis
  - Social, family and medical history
  - Evaluations and assessments

Interview on 8/19/24 client #1 reported:
- Been living at the facility a month
- The Qualified Professional (QP) completed documentation with him when he was admitted
- The QP only talked to him about medication

Interview on 8/20/24 client #1's guardian/sister #1 reported:
- Client #1 was hospitalized at a local psychiatric hospital for 2 weeks prior to admission at the facility
- Worked with the Licensee on client #1's admission to the facility
- Sent the Licensee documentation of client #1's medication and discussed his diagnoses and treatment history
- Remembered completing and signing documentation when client #1 was admitted

Interview on 8/19/24 the former QP reported:
- Last worked at the facility on 6/28/24
- Client #1 admitted in July of 2024
- Was not involved in admission for client #1

Interview on 8/27/24 the QP reported:
- Worked for the facility since 8/4/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0921007	A. BUILDING: _____ B. WING _____	08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABC CARE LP	228 GAIL RIDGE LANE WENDELL, NC 27591

(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 111	Continued From page 9 - Was responsible for completing admission assessments - Was not the QP when client #1 was admitted to the facility - Completed client #1's admission assessment on 8/25/24 Interview on 8/19/24 the House Manager reported: - Worked at the facility for "less than a month" - The QP "would have admitted" client #1 - Attempted to reach the QP on 8/19/24 to ask about client #1's admission assessment but was not successful - Staff #2 "would know who admitted" client #1 Interview on 8/27/24 the Licensee reported: - The House Manager had been working at the facility since 6/28/24 - The House Manager was responsible for "running the home" - Was aware of client #1's admission - The former QP was responsible for client #1's admission assessment	V 111		
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	V 112		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0921007	A. BUILDING: _____ B. WING _____	08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABC CARE LP	228 GAIL RIDGE LANE WENDELL, NC 27591

(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 112	Continued From page 10 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. This Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure a treatment plan was developed and implemented for 1 of 2 audited clients (#1). The findings are: Review on 8/19/24 of client #1's record revealed: - Admitted: 7/8/24 - Diagnoses: Schizophrenia, History of Traumatic Brain Injury, Hyperlipidemia, Back Pain - No treatment plan Interview on 8/19/24 client #1 reported: - Been living at the facility a month - The Qualified Professional (QP) completed documentation with him when he was admitted - He did not discuss goals with the QP	V 112		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0921007	A. BUILDING: _____ B. WING _____	08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABC CARE LP	228 GAIL RIDGE LANE WENDELL, NC 27591

(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 112	Continued From page 11 Interview on 8/20/24 client #1's guardian/sister #1 reported: - Client #1 was hospitalized at a local psychiatric hospital for 2 weeks prior to admission at the facility - Worked with the Licensee on client #1's admission to the facility - Sent the Licensee documentation of client #1's medication and discussed his diagnoses and treatment history - Remembered completing and signing documentation when client #1 admitted - "Thought" she recalled signing a treatment plan Interview on 8/19/24 the former QP reported: - Last worked at the facility on 6/28/24 - Client #1 admitted in July of 2024 - Was not involved in admission for client #1 Interview on 8/27/24 the QP reported: - Worked for the facility since 8/4/24 - Was responsible for completing treatment plans - Was not the QP when client #1 was admitted to the facility - Completed client #1's treatment plan on 8/25/24 Interview on 8/19/24 the House Manager reported: - Worked at the facility for "less than a month" - The QP "would have admitted" client #1 - Attempted to reach the QP on 8/19/24 to ask about client #1's treatment plan but was not successful Interview on 8/27/24 the Licensee reported: - The House Manager had been working at the facility since 6/28/24	V 112		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0921007	A. BUILDING: _____ B. WING _____	08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABC CARE LP	228 GAIL RIDGE LANE WENDELL, NC 27591

(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 112	Continued From page 12 - The House Manager was responsible for "running the home" - Was aware of client #1's admission - The former QP was responsible for client #1's treatment plan	V 112		
V 366	27G .0603 Incident Response Requirements 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	V 366		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0921007	A. BUILDING: _____ B. WING _____	08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABC CARE LP	228 GAIL RIDGE LANE WENDELL, NC 27591

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 366	Continued From page 13	V 366		

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 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0921007	A. BUILDING: _____ B. WING _____	08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABC CARE LP	228 GAIL RIDGE LANE WENDELL, NC 27591

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 366	Continued From page 14 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 three months to submit the final report; and (3) immediately notifying the following: (A) the LME responsible for the catchment area where the services are provided pursuant to Rule .0604; (B) the LME where the client resides, if different; (C) the provider agency with responsibility for maintaining and updating the client's treatment plan, if different from the reporting provider; (D) the Department; (E) the client's legal guardian, as applicable; and (F) any other authorities required by law. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to implement policies governing their response to level I and II incidents as required. The findings are: Review on 8/19/24 of client #1's record revealed: - Admitted: 7/8/24 - Diagnoses: Schizophrenia, History of Traumatic Brain Injury, Hyperlipidemia, Back Pain	V 366		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0921007	A. BUILDING: _____ B. WING _____	08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABC CARE LP	228 GAIL RIDGE LANE WENDELL, NC 27591

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 366	Continued From page 15 - Internal report from staff #1 dated 8/15/24: "[Client #1] was not in his room, he left in the middle of the night. He left his belongings behind. I put a call to his sister (guardian/sister #1) who asked me to relax. She assured me that she will get back to me that [client #1] had early phone that he want to leave the facility. She said he will come back. So on 9:00AM of 8/16/24, I called 911 to report his absence." Review on 8/19/24 and 8/23/24 of the Incident Response Improvement System (IRIS) revealed: - no level II reports from the facility regarding client #1's elopement on 8/15/24 Review on 8/19/24 of the facility's record revealed no incident reports for period 5/1/24 to 8/19/24. There was no evidence of internal review to determine risk/cause analysis of client #1 eloping from the facility. Interview on 8/19/24 client #1 reported: - Had been living at the facility for one month - "Left the other night...when they (staff #1) went to bed" Interviews on 8/19/24, 8/23/24, and 8/28/24 the House Manager reported: - The Qualified Professional (QP) was out of town when the incident occured - He had not been able to reach the QP to notify her of the incident or put additional measures in place for client #1 - Met with the QP on 8/25/24 and implemented measures for client #1, including an unsupervised time plan and a check-in/check out form Interview on 8/27/24 the QP reported: - Been working at the facility since 8/4/24 - Was out of town when client #1 eloped from	V 366		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0921007	A. BUILDING: _____ B. WING _____	08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABC CARE LP	228 GAIL RIDGE LANE WENDELL, NC 27591

(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 16 the facility - Had not determined the cause of the incident - Did not meet with client #1 until 8/25/24 to implement measure to prevent similar incidents from occuring - Client #1 agreed to the additional measures on 8/25/24 and "seemed pleased" - Spoke to the House Manager about the need to "be more structured, find out what [client #1] wants, having a sign in and sign out" - Spoke with staff #1 about the plan regarding client #1's care Interview on 8/19/24 the Licensee reported: - She was aware of client #1 eloping from the facility on 8/16/24 - The House Manager was responsible for "running the home"	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 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:	V 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0921007	A. BUILDING: _____ B. WING _____	08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABC CARE LP	228 GAIL RIDGE LANE WENDELL, NC 27591

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 367	Continued From page 17 (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 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	V 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0921007	A. BUILDING: _____ B. WING _____	08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABC CARE LP	228 GAIL RIDGE LANE WENDELL, NC 27591

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 367	Continued From page 18 .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 review and interview the facility failed to complete a level II incident report to the Local Management Entity/Managed Care Organization (LME/MCO) within 72 hours. The findings are: Review on 8/19/24 of client #1's record revealed: - Admitted: 7/8/24 - Diagnoses: Schizophrenia, History of	V 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0921007	A. BUILDING: _____ B. WING _____	08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABC CARE LP	228 GAIL RIDGE LANE WENDELL, NC 27591

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 367	Continued From page 19	V 367		

Traumatic Brain Injury, Hyperlipidemia, Back Pain
- Internal report from staff #1 dated 8/15/24: "[Client #1] was not in his room, he left in the middle of the night. He left his belongings behind. I put a call to his sister (guardian/sister #1) who asked me to relax. She assured me that she will get back to me that [client #1] had early phone that he want to leave the facility. She said he will come back. So on 9:00AM of 8/16/24, I called 911 to report his absence."

Interview on 8/19/24 client #1 reported:
- Had been living at the facility for one month
- "Left the other night...when they (staff #1) went to bed"

Review on 8/19/24 and 8/23/24 of the Incident Response Improvement System (IRIS) revealed:
- no level II reports from the facility regarding client #1's elopement on 8/15/24

Review on 8/19/24 of the facility's records revealed no incident reports for period 5/1/24 to 8/19/24.

Interviews on 8/19/24, 8/23/24, and 8/28/24 the House Manager reported:
- The Qualified Professional (QP) was out of town when the incident occured
- On 8/19/24, the IRIS report had not been completed but the current QP was "about to do it"
- On 8/28/24, the current QP attempted to complete the IRIS on 8/25/24 but was not able to complete it because the facility information was not avaiable in the IRIS system

Interview on 8/27/24 the QP reported:
- Been working at the facility since 8/4/24
- She was out of town when client #1 eloped from the facility

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0921007	A. BUILDING: _____ B. WING _____	08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABC CARE LP	228 GAIL RIDGE LANE WENDELL, NC 27591

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 367	Continued From page 20 - She attempted to complete the IRIS report on 8/25/24 but the facility information would not populate in the IRIS system Interview on 8/19/24 the Licensee reported: - She was aware of client #1 eloping from the facility on 8/16/24 - The House Manager was responsible for "running the home"	V 367		