STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			A. BOILDING.		С	
		MHL032-507	B. WING			17/2024
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MAKIN'	CHOICES, INC			TREET, BUILDING 900		
			NC 27704			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
V 000	INITIAL COMMENT	rs	V 000			
	17, 2024. The comp (intake #NC002203 This facility is licens	was completed on September plaint was substantiated 81). Deficiencies were cited. sed for the following service AC 27G .2300 Adult				
	Developmental and Individuals with Dev	Vocational Programs for velopmental Disabilities and 00 Day Activity for Individuals				
	.2300 Adult Develop Programs for Individual Disabilities has a cu Day Activity for Individual has a current censul consisted of audits	urrent census of 45. The pmental and Vocational duals with Developmental urrent census of 0. The .5400 viduals of All Disability Groups us of 45. The survey sample of 1 current Day Activity for sability Groups client.				
V 108	27G .0202 (F-I) Per	rsonnel Requirements	V 108			
	(g) Employee training provided and, at a refollowing: (1) general organiz (2) training on clier delineated in 10A N 10A NCAC 26B; (3) training to meet client as specified in plan; and (4) training in infect bloodborne pathogo (h) Except as perm	cation shall be documented. ing programs shall be minimum, shall consist of the cational orientation; nt rights and confidentiality as ICAC 27C, 27D, 27E, 27F and t the mh/dd/sa needs of the n the treatment/habilitation tious diseases and				

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

(X6) DATE TITLE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
					(0	
		MHL032-507	B. WING		09/1	17/2024	
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE			
MAKIN'	CHOICES, INC		TH DUKE ST NC 27704	TREET, BUILDING 900			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE	
V 108	member shall be ave times when a client member shall be traincluding seizure member to provide cardioput trained in the Heimstechniques such as the American Heart equivalence for relicity. The governing beimplement policies reporting, investigat	ge 1 vailable in the facility at all is present. That staff ained in basic first aid anagement, currently trained Imonary resuscitation and ich maneuver or other first aid those provided by Red Cross, Association or their eving airway obstruction. ody shall develop and and procedures for identifying, ting and controlling infectious diseases of personnel and	V 108				
	interviews, the facil three audited staff (meet the needs of a Review on 9/6/24 or -Admission date of -Diagnoses of Cere Bladder, History of Hand Contracture of Migraine Headacher Reviews on 9/6/24 records revealed: Staff #1Hired as a Habilital-Date of hire (DOH)	on, record reviews and lity failed to ensure three of #1, #2 and #3) had training to a client. The findings are: If client #1's record revealed: 6/20/17. Ibral Palsy, Neurogenic Rectal Ulcer, Osteoporosis, of hand joint and History of is. and 9/16/24 of personnel					

Division of Health Service Regulation

STATE FORM 3EE911 If continuation sheet 2 of 15

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		MUI 022 507	B. WING		 	C 17/2024
NAME OF I		MHL032-507	<u> </u>		09/	17/2024
	PROVIDER OR SUPPLIER			STATE, ZIP CODE TREET, BUILDING 900		
MAKIN'	CHOICES, INC		, NC 27704	, _0		
(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 (EACH CORRECTIVE ACTION (EACH) (EA	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
V 108	Continued From pa	ge 2	V 108			
	carries) dated 12/13 -There was no clier	mpetencies (transfers and				
	and lifting training d -Client Specific Cor carries) dated 12/13 -There was no clier	3. nds on/Changing/Transport lated 12/13/23. npetencies (transfers and				
	and lifting training d	nds on/Changing/Transport lated 6/12/24.				
	of the facility's chan	/24 at approximately 11:15 am aging room revealed: ushed against the wall.				
	dated 1/24/24 reveault - "At approximately 1-24-24, after changles assisting [Staff #2] changing, had his legs and feet and transitioning him from 1-2-3 lift as we move the chair we heard was sat in the chair	1:10 pm on Wednesday ging [client #1], [Staff #1], in transporting [client #1] for upper body and [Staff #2] had				

Division of Health Service Regulation

STATE FORM STATE FORM SEE911 If continuation sheet 3 of 15

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2609 NORTH DUKE STREET, BUILDING 900 DURHAM, NC 27704 CALL DEPLICENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDER'S PLAN OF CORRECTION (EACH DEPLICENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH DEPLICENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DIFFERENCED TO THE APPROPRIATE DEPLICATION OF THE APPROPRIATE DEPLICATI	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		·	E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED	
MAKIN' CHOICES, INC 2609 NORTH DUKE STREET, BUILDING 900 DURHAM, NC 27704 CALIDER PROVIDER OR SUPPLIER 2609 NORTH DUKE STREET, BUILDING 900 DURHAM, NC 27704 CALIDER PROVIDER'S PLAN OF CORRECTION (EACH DEPICIENCY MUST BE PRECEDED BY FULL TAG PROVIDER'S PLAN OF CORRECTION (EACH DEPICIENCY MUST BE PRECEDED BY FULL TAG PREPIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION) SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE							С
MAKIN' CHOICES, INC SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) V 108 Continued From page 3 looked different. [Client #1] didn't complain of pain, however. [client #1] said look at. Upon checking it was found to look dislocated/broken as it looked different from his normal. [The Program Director] was noticed to call 9-1-1 due to incident and ambulance was dispatched" Review on 9/10/24 of a discharge summary from local hospital revealed: -Client #1 was admitted on 1/24/24 and discharged on 1/25/24Client #1 had an acute fracture of the mid right humeral diaphysis with apex medical (mid right arm humeral fracture)Client #1 received an orthopedic splint and sling for the fractureClient #1 and susgical procedure for the mid right arm humeral fracture. Interview on 9/6/24 with client #1 revealed: -His arm was broken in January 2024 -Staff #1 and staff #2 were putting him back into his wheelchair and his right arm ht the left side of his wheelchairHe laid on the bed initially because staff changed his adult diaperOne of the staff stood near the head of the bed and the other staff stood near his feetThe staff near the head of the bed lifted his			MHL032-507	B. WING		09/	17/2024
XA ID SUMMARY STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCIES FREERIX TAG SUMMARY STATEMENT OF DEFICIENCIES PREERIX TAG SUMMARY STATEMENT OF DEFICIENCES PREERIX TAG PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE V 108 Continued From page 3 V 108 Continued From page 3 Continued From page 3 Continued From page 3 Continued From his normal. The Program Director Was noticed to call 9-1-1 due to incident and ambulance was dispatched" Review on 9/10/24 of a discharge summary from local hospital revealed: Client #1 was admitted on 1/24/24 and discharged on 1/25/24. Client #1 dad an acute fracture of the mid right humeral diaphysis with apex medical (mid right arm humeral fracture). Client #1 had no surgical procedure for the mid right arm humeral fracture. Interview on 9/6/24 with client #1 revealed: -His arm was broken in January 2024 -Staff #1 and staff #2 were putting him back into his wheelchair and his right arm hit the left side of his wheelchair. -He laid on the bed initially because staff changed his adult diaper. -One of the staff stood near the head of the bed and the other staff stood near the head of the bed and the other staff stood near the head of the bed infed his	NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) V 108 Continued From page 3 looked different. [Client #1] didn't complain of pain, however; [client #1] said look at. Upon checking it was found to look dislocated/broken as it looked different from his normal. [The Program Director] was noticed to call 9-1-1 due to incident and ambulance was dispatched" Review on 9/10/24 of a discharge summary from local hospital revealed: -Client #1 was admitted on 1/24/24 and discharged on 1/25/24. -Client #1 had an acute fracture of the mid right humeral diaphysis with apex medical (mid right arm humeral fracture). -Client #1 had no surgical procedure for the mid right arm humeral fracture. Interview on 9/6/24 with client #1 revealed: -His arm was broken in January 2024 -Staff #1 and staff #2 were putting him back into his wheelchairHe laid on the bed initially because staff changed his adult diaperOne of the staff stood near the head of the bed and the other staff stood near his feetThe staff near the head of the bed lifted his	MAKIN'	CHOICES, INC			TREET, BUILDING 900		
looked different. [Client #1] didn't complain of pain, however; [client #1] said look at. Upon checking it was found to look dislocated/broken as it looked different from his normal. [The Program Director] was noticed to call 9-1-1 due to incident and ambulance was dispatched" Review on 9/10/24 of a discharge summary from local hospital revealed: -Client #1 was admitted on 1/24/24 and discharged on 1/25/24. -Client #1 had an acute fracture of the mid right humeral diaphysis with apex medical (mid right arm humeral fracture). -Client #1 received an orthopedic splint and sling for the fracture. -Client #1 had no surgical procedure for the mid right arm humeral fracture. Interview on 9/6/24 with client #1 revealed: -His arm was broken in January 2024 -Staff #1 and staff #2 were putting him back into his wheelchair: -He laid on the bed initially because staff changed his adult diaper. -One of the staff stood near the head of the bed and the other staff stood near his feet. -The staff near the head of the bed lifted his	PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF	HOULD BE	COMPLETE
upper body and the other staff lifted his legsHe could not remember which staff stood where during the incidentHe was in a "little bit" of pain when his arm hit the chair. Interview on 9/9/24 with client #1's sister revealed: -In January 2024 staff were transferring client #1 back into his wheelchair.	V 108	looked different. [C pain, however; [clie checking it was fou as it looked differer Program Director] vincident and ambul Review on 9/10/24 local hospital reveation -Client #1 was admidischarged on 1/25-Client #1 had an a humeral diaphysis arm humeral fractureClient #1 received for the fractureClient #1 had no sright arm humeral from the fractureClient #1 had no sright arm humeral from the fractureClient #1 had no sright arm humeral from the fractureClient #1 had no sright arm humeral from the fractureClient #1 and staff #1 and the other staff his wheelchairHe laid on the bed his adult diaperOne of the staff stand the other staff -The staff near the upper body and the -He could not remeduring the incidentHe was in a "little I the chair. Interview on 9/9/24 revealed: -In January 2024 staff -In	lient #1] didn't complain of ent #1] said look at. Upon and to look dislocated/broken at from his normal. [The was noticed to call 9-1-1 due to ance was dispatched" of a discharge summary from aled: aitted on 1/24/24 and 5/24. acute fracture of the mid right with apex medical (mid right with apex medical (mid right are). an orthopedic splint and sling an orthopedic splint and sling urgical procedure for the mid fracture. with client #1 revealed: an in January 2024 #2 were putting him back into his right arm hit the left side of a initially because staff changed bood near the head of the bed stood near his feet. head of the bed lifted his a other staff lifted his legs. Ember which staff stood where the bit of pain when his arm hit with client #1's sister thaff were transferring client #1	V 108			

Division of Health Service Regulation

STATE FORM 3EE911 If continuation sheet 4 of 15

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		A. BUILDING:				
	MHL032-507	B. WING			C 17/2024	
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
MAKIN' CHOICES, INC		RTH DUKE ST , NC 27704	FREET, BUILDING 900			
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE	
arm "snapped." -"Staff must secure being transferred du -"Staff should have his arm and this wo -"[Client #1"] arms h arms can't be kept I -"I feel like staff wer and that was how hi -"I feel staff were not had a broken bone Interviews on 9/9/24 revealed: -There was an incidelt was time for clierestaff #2 was the ot incidentHe (Staff #1) had the bodyHe "grabbed" cliented him from the collented him from	the side of his chair and the [client #1's] arms when he is ue to the muscle spasms." come up with a way to control uld have never happened." have to strapped down, his loose." re not lifting [client #1] properly is arm was broken." of trained properly. He never prior to that incident." 4 and 9/16/24 with staff #1 Hent on 1/24/24 with client #1. ht #1 to be changed. her staff helping the day of the he upper portion of client #1's t #1 underneath his arms. around [client #1's] chest to then lifted [client #1]." ere hanging loose when he changing bed. wer portion of client #1's body, her how staff #2 lifted client 2. 3" and lifted client #1 from the his wheelchair. client #1 from the changing hair, they heard a "pop." t #1's arm hit anything. him and said "broke." ree twig breaking, it was a	V 108				

Division of Health Service Regulation

STATE FORM 3EE911 If continuation sheet 5 of 15

DIVISION	of Health Service Re	guiation				
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		MHL032-507	B. WING			, 7/2024
		WITTE032-307			09/1	112024
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MAZINI	CHOICES INC	2609 NOF	RTH DUKE S	TREET, BUILDING 900		
WANIN	CHOICES, INC	DURHAM	, NC 27704			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON	(X5)
PREFIX		MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL		COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROI DEFICIENCY)	PRIATE	DATE
				DEI ICIENCI)		
V 108	Continued From pa	ge 5	V 108			
		_				
		ssibly hit the side of the				
	wheelchair and brol					
	what was going on.	gram Director and told him				
		al Services (EMS) were called				
	and client #1 went t	,				
		t he never received training to				
	help with lifting and					
		e staff asked him to help with				
	client #1.	otan donoù min to noip mar				
		o just lift client #1's upper				
	body.	- Just				
		mber that staff's name.				
	-He did not recall si	gning a sheet to acknowledge				
	he received training	to lift and transfer client #1.				
	-He watched other	staff lifting and transferring				
	client #1 and "that v	vas how I learned."				
		ng and transferring [client #1]				
		tween November 2023 and				
	January 2024 prior					
		dditional training after the				
	incident.	toff ware told to met the				
		taff were told to get the shirt and wrap his arms in				
	front of his body.	s stillt attu wrap tils attils itt				
	,	3rd staff would assist				
	whenever client #1					
		trained properly to help lift				
	and transfer client #					
		n 1/24/24 he helped a few				
		ng and transferring client #1,				
	"but I never felt com					
	-"I possibly helped a	another 12 or more times after				
	the incident."					
		4 with staff #2 revealed:				
		vas an incident with client #1.				
		went into the changing room.				
		the room to help her lift and				
	transfer client #1 be	ecause he needed his adult				

Division of Health Service Regulation

STATE FORM 3EE911 If continuation sheet 6 of 15

Division	of Health Service Re	egulation			_	
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
						:
		MHL032-507	B. WING		1	7/2024
		0.70557.40		714TE 710 000E		
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
MAKIN' (CHOICES, INC			TREET, BUILDING 900		
		DURHAM	NC 27704			
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPRO		DATE
				DEFICIENCY)		
V 108	Continued From pa	age 6	V 108			
V 100	Continued i form pa	ige o	V 100			
	diaper changed.					
		d changing client #1, they				
		t #1 back into his wheelchair.				
		hair was near the bed.				
		hind the wheelchair and				
		ms because client #1's arms				
	· ·	o his Cerebral Palsy.				
	waist.	bbed" client #1 around his				
		nt #1 around his knees.				
		ent #1 from his chair.				
		ferring client #1 to his				
		#1's] right arm flew over				
	because he had a r					
	-They then heard a					
	-She never saw his					
	-Client #1 said "my	arm."				
		at his arm, "it was just				
	hanging."					
		te a question mark."				
		Program Director and he				
	called 911.					
		nt she was not trained to lift				
	and transfer clients	here are trained to lift and				
	transfer clients."	ilere are trained to fire and				
		on 1/24/24 she was not aware				
		changes for how staff lift and				
	transfer client #1.	900				
		ny training related to that				
	incident on 1/24/24					
		pe of training, I don't care what				
	kind of sheet they o					
		size bed they use in the				
		enever they change client #1.				
		hospital bed that goes up and				
	down for client #1.	and the dark and				
	-Staff could really h	urt their back.				
	Interview on 9/16/2	4 with staff #2 revealed:				

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A. BUILDING: COMPLETE CO	
MHL032-507 B. WING 09/17/2	
	2024
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
MAKIN' CHOICES, INC 2609 NORTH DUKE STREET, BUILDING 900 DURHAM, NC 27704	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
"We sign a lot of documents, however I did not recall signing a document to acknowledge I was trained to lift and transfer clients." "We really don't go over what we sign to be honest, we just sign the document." -She watched two people lift and transfer client #1 when she first started working with him. -The Program Director and another staff showed her how to lift and transfer client #1. "I guess that was what was considered the training." "It was not a step-by-step process like some of the other trainings we completed." Interview on 9/12/24 with staff #3 revealed: -He was "[client #1s] 1:1 staff on and off." -He was "[client #1s] 1:1 staff on and off." -He watched the Program Director and a former staff transfer client #1 when he started. "That was how I learned how to lift and transfer [client #1]." -He did not have a formal training. Interviews on 9/6/24, 9/13/24 and 9/17/24 with the Program Director revealed: -He was aware of the incident with client #1's arm being fractured on 1/24/24. -He called EMS immediately once staff brought the incident to his attention. -He did an additional training a couple of months after that 1/24/24 incident. -Staff #1 and staff #2 did not receive the training in June 2024 because they are no longer working with client #1 was away from the facility for a few months after he fractured his arm. -They were not sure if client #1 was going to return to the facility. -During that June 2024 training staff were told to ensure client #1's arms were secured during transfers.	

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MUI 022 507	B. WING		00/4	
		MHL032-507			09/1	7/2024
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
MAKIN' (CHOICES, INC		NC 27704	TREET, BUILDING 900		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
V 108	Continued From pa	ge 8	V 108			
V 108	-There was not a transferring clientsHe only trained state #1's 1:1 staff"Once staff are transferring of training was of arm being fracturedThey did training to and off" over the last of training was of #1's staff changingThey did a hands of after client #1 fract of (1/24/24) as wellShe did the transfe 6/12/24Staff #3 did the transfe 6/12/24Staff #3 did the transfe for training because the #1The Qualified Profit training with Staff #1.	aining certificate for lifting and Iff who were assigned as client ined, they sign off to aining was received." 4 and 9/16/24 with the Chief evealed: the incident with client #1's I on 1/24/24. o transfer and lift client #1 "on est few years. one several times due to client on transfer and lift training ured his arm in January 2024 er and lift training with staff on ining with her. that training about 20 years te training that was done mental health facility]." #2 were not a part of that ey no longer worked with client essional did the 12/13/23	V 108			
	to lift and transfer.	of a Plan of Protection written				

Division of Health Service Regulation STATE FORM

3EE911 If continuation sheet 9 of 15

PRINTED: 09/23/2024 FORM APPROVED

Division of Health Service Regulation

ווטופועום	of Health Service Re	guiation				
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
						:
		MHL032-507	B. WING			7/2024
				2747F 7ID 00DF		
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
MAKIN'	CHOICES, INC			TREET, BUILDING 900		
	•	DURHAM	NC 27704			_
(X4) ID	_	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION SHOULD		(X5)
PREFIX TAG		' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI		COMPLETE DATE
		,		DEFICIENCY)		
\/ 108	Continued From pa	go 0	V 108			
V 100	-		V 100			
		ofessional dated 9/17/24				
	revealed:					
		ction will the facility take to				
		f the consumers in your care?				
		roughout all levels of service				
		pices Inc. will implement the				
		and procedures immediately.				
		aff on elements of the approve noices Inc. This training will be				
		supervision monthly. All				
		ers within the program will be				
		I of low, medium, moderate				
		s of need to determine the				
		posure. A decision will be				
		eds and the level of are				
	required. High risk i	ndividuals that have been				
	deemed medical fra	agility. A consumer's health				
		ment that requires a higher				
		n is outside of our scope of				
		essed and they fall within the				
		ategory, we will coordinate and				
		olicable to determine the best				
		scharge. Describe your plans				
		pove happens. The clinical ices Inc. will receive training				
		onstration, hands on,				
		, lifting and positioning. Within				
		ill be trained on how to				
		addings and other restraints to				
		nt #1] from wheelchair. Staff				
		on positioning of [client #1's]				
		afely transport [client #1] from				
		ging bed. Staff will also be				
	trained on all safety	equipment to include				
		equipment (PPE) to ensure				
		o [client #1's] wheelchair to				
		to wheelchair. Training will be				
		Supervision will be provided				
		ns will identify the train/retrain				
	that was provided for	or consumers that are				

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
					С	
		MHL032-507	B. WING		1	7/2024
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
MAKIN'	CHOICES, INC		TH DUKE S' NC 27704	TREET, BUILDING 900		
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
V 108	applicable. Observaneeded. Makin Chothe level for all indivprogram to determinexposure. The tools Individualized Suppassessment, Behaving past and present in any other applicable level of determinativiolations immediativiolations immediativiolations immediativiolations immediativiolations immediately. All appropriate of the contacted." Client #1's diagnose Neurogenic Bladde Osteoporosis, Hand History of Migraine incident on 1/24/24 staff #2 were transf wheelchair after chapter after the sustained a mid Client #1 stayed ov returned to his resident, Staff #2 and Stain any formal training specifically client #1 watched other staff they started working how they learned to Staff #1 and staff #1 transfer client #1 af client #1 fractured for This deficiency con	ation will be conducted as sices will meet and determine viduals participating in the day ne the level of risk and a that will be used is the ort Plan (ISP), risk vioral Support Plans (BSP's), cident/accident reports, and a correspondence to make our on. To address these ely we are moving forward of [client #1] effective olicable parties will be es included Cerebral Palsy, r, History of Rectal Ulcer, d Contracture of hand joint and Headaches. There was an with client #1. Staff #1 and erring client #1 back into his anging his adult diaper. Client e side of his wheelchair and right arm humeral fracture. ernight at the hospital and dential facility on 1/25/24. Staff aff #3 stated they did not have to lift and transfer client #1 when g at the facility and that was a lift and transfer client #1. 2 had no training to lift and ter the 1/24/24 incident when his arm. stitutes a Type A1 rule harm and neglect and must	V 108			

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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	
			7t. Boilbirto.			С	
		MHL032-507	B. WING			17/2024	
NAME OF I	PROVIDER OR SUPPLIER			TATE, ZIP CODE			
MAKIN'	CHOICES, INC		RTH DUKE S ⁻ , NC 27704	FREET, BUILDING 900			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE	
V 112	Continued From pa	 ige 11	V 112				
V 112	27G .0205 (C-D) Assessment/Treatr	nent/Habilitation Plan	V 112				
	PLAN (c) The plan shall to assessment, and in legally responsible of admission for clir receive services beto (d) The plan shall in (1) client outcome (achieved by provisi projected date of action (2) strategies; (3) staff responsible (4) a schedule for annually in consultar responsible person (5) basis for evalua outcome achievem (6) written consent responsible party, or provider stating why obtained. This Rule is not me Based on record responsible party.	De developed based on the partnership with the client or person or both, within 30 days ents who are expected to eyond 30 days. Include: (s) that are anticipated to be on of the service and a chievement; (le; review of the plan at least ation with the client or legally or both; ation or assessment of ent; and a cor agreement by the client or or a written statement by the y such consent could not be et as evidenced by: et as evidenced by: eview and interviews, the					
	facility failed to dev	elop and implement strategies of one of one client (#1). The					

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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			
					С			
		MHL032-507	B. WING		09/1	17/2024		
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE								
MAKIN' CHOICES, INC 2609 NORTH DUKE STREET, BUILDING 900 DURHAM, NC 27704								
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE		
V 112	Continued From page 12		V 112					
	findings are:							

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BOILDING.			
		MHL032-507	B. WING		1	7/2024
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STATE, ZIP CODE			
MAKIN'	CHOICES, INC		TH DUKE S' NC 27704	TREET, BUILDING 900		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
V 112	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		V 112	DETIGIENCI)		

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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			
	MUI 022 507	B WING		00/4			
	MHL032-507	<u> </u>		09/1	7/2024		
NAME OF PROVIDER OR SUPPLIER			STATE, ZIP CODE				
MAKIN' CHOICES, INC 2609 NORTH DUKE STREET, BUILDING 900 DURHAM, NC 27704							
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY 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		
folded client #1's a were "flailing" due -Staff #2 then "gra waistShe "grabbed" cli -They then lifted c -As they were tran wheelchair "[client because he had a -They then heard a -She never saw hi -Client #1 said "my -When she looked hanging." -His arm "looked li -She called for the called 911. Interviews on 9/6/2 Program Director -He was aware of being fractured on -He called Emerge immediately once attentionThe Local Manag Organization was plan for client #1"We didn't realize #1] that needed to -He confirmed the	ehind the wheelchair and arms because client #1's arms to his Cerebral Palsy. bbed" client #1 around his ent #1 around his knees. ient #1 from his chair. sferring client #1 to his #1's] right arm flew over muscle spasm." a "crack noise." s arm hit anything. y arm." at his arm, "it was just ke a question mark." Program Director and he 24 and 9/17/24 with the revealed: the incident with client #1's arm	V 112	DEL MICHOLY)				

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