

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL092-411</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R-C 09/20/2024</b>
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NAME OF PROVIDER OR SUPPLIER  <b>THOMAS SUPERVISED CARE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>7016 BEAVERWOOD DRIVE RALEIGH, NC 27616</b>
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(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
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V 367	<p>Continued From page 11</p> <p>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:</p> <p>(1) reporting provider contact and identification information;</p> <p>(2) client identification information;</p> <p>(3) type of incident;</p> <p>(4) description of incident;</p> <p>(5) status of the effort to determine the cause of the incident; and</p> <p>(6) other individuals or authorities notified or responding.</p> <p>(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:</p> <p>(1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or</p> <p>(2) the provider obtains information required on the incident form that was previously unavailable.</p> <p>(c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including:</p> <p>(1) hospital records including confidential information;</p> <p>(2) reports by other authorities; and</p> <p>(3) the provider's response to the incident.</p> <p>(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</p>	V 367	<p>V 367 Incident Reporting</p> <p>V 367 Incident Reporting Requirements</p> <p>It is the responsibility of the QP to complete level 2 and 3 incidents in IRIS within 72 hours of their occurrence. The QP will ensure that incident reports are completed within the required times frames. As of 9/20/24, the QP has provided training to the administrator on how to complete Level II &amp; III incident reports in IRIS and has provided training to the staff on reporting protocols as well as reporting incidents to the QP during or immediately following an incident.</p>	
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V 367	<p>Continued From page 12</p> <p>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).</p> <p>(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:</p> <ol style="list-style-type: none"> <li>(1) medication errors that do not meet the definition of a level II or level III incident;</li> <li>(2) restrictive interventions that do not meet the definition of a level II or level III incident;</li> <li>(3) searches of a client or his living area;</li> <li>(4) seizures of client property or property in the possession of a client;</li> <li>(5) the total number of level II and level III incidents that occurred; and</li> <li>(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.</li> </ol> <p>This Rule is not met as evidenced by: Based on record review and interview the facility</p>	V 367		

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V 367	<p>Continued From page 13</p> <p>failed to ensure a Level II incident reported was submitted to the Local Management Entity/Managed Care Organization. The findings are:</p> <p>Review on 9/12/24 of the Incident Response Improvement System (IRIS) revealed:</p> <ul style="list-style-type: none"> <li>- no documentation of a 3/28/24 incident</li> </ul> <p>Review on 9/12/24 of a facility's level one incident report dated 3/28/24 revealed:</p> <ul style="list-style-type: none"> <li>- "...staff was upstairs preparing dinner when staff heard a loud thump. The consumer was in his room when staff was upstairs preparing dinner. staff came downstairs to find consumer (FC#5) sitting on the floor with the back of his head bleeding. Staff applied first aid to stop bleeding and bandaged his wound...took consumer to the emergency room...staples (3) in his head..."</li> </ul> <p>During interview on 9/12/24 the Licensee reported:</p> <ul style="list-style-type: none"> <li>- his case management office was supposed to submit the incident reports</li> </ul>	V 367		
V 784	<p>27G .0304(d)(12) Therapeutic and Habilitative Areas</p> <p>10A NCAC 27G .0304 FACILITY DESIGN AND EQUIPMENT</p> <p>(d) Indoor space requirements: Facilities licensed prior to October 1, 1988 shall satisfy the minimum square footage requirements in effect at that time. Unless otherwise provided in these Rules, residential facilities licensed after October 1, 1988 shall meet the following indoor space requirements:</p> <p>(12) The area in which therapeutic and</p>	V 784		

Division of Health Service Regulation

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V 784	<p>Continued From page 14</p> <p>habilitative activities are routinely conducted shall be separate from sleeping area(s).</p> <p>This Rule is not met as evidenced by: Based on observation and interview the facility failed to ensure therapeutic and habilitative activities were routinely conducted and were separate from sleeping areas. The findings are:</p> <p>Observation on 9/12/24 at 11:58pm of the facility revealed:</p> <ul style="list-style-type: none"> <li>- downstairs area had a sitting area with recliners and a couch</li> </ul> <p>During interview on 9/18/24 staff #5 reported:</p> <ul style="list-style-type: none"> <li>- he was the weekend staff</li> <li>- came in on Fridays and left on Sundays</li> <li>- he slept on the couch in the downstairs area</li> <li>- he could better monitor client #4 and FC#5 when he slept downstairs</li> </ul> <p>During interview on 9/20/24 the Licensee reported:</p> <ul style="list-style-type: none"> <li>- was aware staff #5 slept on the couch downstairs</li> <li>- he planned to make the staff's office into a bedroom</li> </ul>	V 784	<p>784 Therapeutic and Habilitative Areas</p> <p>At no time will a staff use a common area of the home as a place to sleep. The staff have a designated area for sleeping. Any awake staff will remain awake during their designated work hours . Any person assigned to work overnight will sleep in the approved staff area.</p>	
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FC#4



Alliance Health

North Carolina Division of Mental Health, Developmental Disabilities and Substance Abuse Services

Name: [Redacted]  
Medical: [Redacted]

Date of Birth: [Redacted]

Record [Redacted]  
ISP Start Date: [Redacted]

**Update to Individual Support Plan**

Meeting Date: 10/11/2024

Implementation Date: 10/14/2024

**What is happening in my life right now?\***

[Redacted] was only approved for level 4 residential services for only 2 months due to the lack of supporting documentation. His service reduced to level 3 after the first 2 months of the plan year.

**What needs to change?\***

Due to [Redacted] being approved for level 3 residential supports, he no longer requires 1:1 staffing. All long range goals have been updated to reflect the change. [Redacted] level 3 supports (1:1 supports no longer required) were effective as of 3/1/2024.

**My Action Plan**

Long-Range Goal 1: [Redacted] works on daily hygiene and housekeeping skills. Who helps me: Professional Supports

How and how often (service/frequency): Residential Level 3 | 24/7

Where am I now: [Redacted] requires partial physical assistance & coaching for housekeeping. Right now, he only cleans his own room, but they are working on getting [Redacted] to work on doing chores around the house. His housemates are doing his chores right now. They are currently working on sweeping the floor outside of his room & cleaning the bathroom. Staff is working on getting [Redacted] up at the same time each day and immediately take a shower to help wake him up. [Redacted] clothing tends to get soiled, and he does not notice the stains. He often wipes his hands on his shirt instead of using a napkin. He requires partial physical assistance to clean himself after a bowel movement and he needs to work on closing the door when he does use the bathroom. He requires coaching to wash his hands.

Name: [REDACTED] Date of Birth: [REDACTED] [REDACTED]  
Medication: [REDACTED] ISP Start Date: 10/14/2024

2023: Staff tend to let [REDACTED] do his part with daily hygiene & housekeeping, then they will finish for him. [REDACTED] will try to clean himself after a bowel movement, but most of the time he needs staff to complete this task. He needs reminders to wash his hands, or he will just walk off. They are trying to get him to sweep or mop but requires partial physical assistance. He does attempt to make his bed and will put things away. He can put on his fitted sheet when putting on clean sheets.

Where: Home & Community

Target Date: 02/28/2025

Long-range Goal 2: [REDACTED] will work on finding activities outside of his group home to do.

Who helps me: Professional Supports

How and how often (service/frequency): Residential Level 3 | 24/7

Where am I now: Life-long learning is essential for [REDACTED] by leading a more independent life and taking an active part in society. Educate [REDACTED] to engage in tasks involving peer interaction, making decisions, and solving problems. Educate [REDACTED] how to advocate for himself, including understanding his rights, and learning how stand up for himself by practicing communication of his needs and concerns.

2023: They are doing the same things they have been doing. [REDACTED] goes to the mall to walk or goes on car rides to get take-out food. They have gone out to eat. Team is working hard to keep [REDACTED] active.

Where: Home & Community

Target Date: 02/28/2025

Long-range Goal 3: [REDACTED] engages in tasks involving peer interaction, making decisions, and solving problems.

Who helps me: Professional Supports

How and how often (service/frequency): Residential Level 3 | 24/7 & IND Day Supports – 30hrs/wk

Where am I now: It is important for [REDACTED] to learn key socialization/communication skills and behaviors. [REDACTED] requires ongoing guidance to improve his socialization skills as evidenced by to greet/engage in nonverbal discussion with others appropriately. It is important to [REDACTED] to engage in tasks involving peer interaction, making decisions, and solving problems.

2023: Choices with regards to food continue to motivate [REDACTED]. He continues to need partial to full physical assistance for this goal. His housemates consider [REDACTED] their “baby” and try to look after him. He has a housemate who tries to interpret for

**Alliance Health**

North Carolina Division of Mental Health, Developmental  
Disabilities and Substance Abuse Services

Name: [REDACTED] Date of Birth: [REDACTED] [REDACTED]  
Medi [REDACTED] ISP Start Date: 10/14/2024

him and looks after him as he does the other housemates. If he has what he needs, he is less likely to engage. Staff typically engage him and ask him questions with prompts to get him to respond. He will say good morning when prompted and non-verbally indicate he is ready to eat. He will often engage with one staff more than others. Team feels like it is the staff who comes right before dinner. He will try to use signs and words when motivated. He makes a lot of happy noises at night. You can tell he is happy when he gets his YouTube videos on and runs around with them on.

Where: Home & Community

Target Date: 02/28/2025

**Long-range Goal 4: Learn communication and related skills to prevent angry outburst and personal disputes.**

Who helps me: Professional Supports

How and how often (service/frequency): Residential Level 3 | 24/7 & IND Day Supports – 30hrs/wk

Specialized Consultative Services – 5hrs/yr (BSP)

Where am I now: [REDACTED] has a history of challenging behaviors which include verbal and physical aggression. He has been known to assault & injure others, along with a history of breaking personal items. [REDACTED] is known to scream, holler, and attempt to intimidate others. Outbursts could occur a few times per week and sometimes daily. He misjudges social cues, body language, and voice tones. Which would lead him to becoming aggressive. [REDACTED] does not understand when he is told “no” and requires guidance to learn strategies to manage his anger. [REDACTED] continues to require guidance to communication his needs and wants.

2023: [REDACTED] will charge towards people if his anxiety increases, so staff cannot let their guard down. His anxiety does increase in the evenings, and this is when he is most alert. He might need a few more prompts in the evenings to prevent outburst. Going to bed is not the same as going to sleep. It takes him about an hour to go to sleep from the time he goes to bed and then goes to sleep. They report that he will have an emotional outburst if his food is not on time or if he sees something someone else is eating and he wants that. He might require up to 5 cues to help him stop charging, grabbing, and or/shaking someone. Mother reported that [REDACTED] charged at and pushed her once in 2023 after she clapped her hands and again on 1/31/24 in which staff had to intervene.

Where: Home & Community

Target Date: 02/28/2025

Goal 5: [REDACTED] allow others to maintain his nails.

Who helps me: Professional Supports

How and how often (service/frequency): Specialized Consultative Services – 5hrs/yr

**Alliance Health**

North Carolina Division of Mental Health, Developmental Disabilities and Substance Abuse Services

Name: [REDACTED] Date of Birth: [REDACTED] Record #: [REDACTED]  
 Medicaid: [REDACTED] ISP Start Date: 10/14/2024

(OT/PT/SLP); Residential Level 3 | 24/7

**Where am I now:** [REDACTED] has a really hard time letting people cut his fingernails and toenails. They need to keep his nails trimmed at the group home, so he doesn't hurt himself or others. [REDACTED] does not like water in his face and team could use some suggestions on how to help [REDACTED] with this. He is ok with hair trims and shaving.

**2023:** [REDACTED] gets his toenails cut by a podiatrist appointments every 3 months. His 1:1 will go with him. Mom files his fingers nails down

**Where:** Home & Community

**Target Date:** 02/28/2025

**Goal 6:** [REDACTED] is safe at home and when out in the community.

**Who helps me:** Professional Supports

**How and how often (service/frequency):** Residential Level 3 | 24/7 & IND Day Supports – 30hrs/wk

**Where am I now:** [REDACTED] currently requires 1staff during all awake hours. He needs reminders to keep his mask on when out in the community and he must be reminded to wash his hands. He is good at social distancing. He requires coaching to partial physical assistance to avoid health and safety hazards. He is non-verbal. He requires partial physical assistance for advocating for himself, protecting self from exploitation, and managing any money he has. [REDACTED] will get excited when he sees certain strangers and might run up to them and start jumping.

**Where:** Home & Community

**Target Date:** 02/28/2025

Demographic Information

Name	[REDACTED]	Medicaid County	Wake
Date of Birth	[REDACTED]	Medicare #	
Address	[REDACTED]	Insurance Carrier	
City, State, Zip	[REDACTED]	Insurance #	
Home Phone:	[REDACTED]	Other Phone:	
Cell Phone:	[REDACTED]	Email:	



**Alliance Health**

North Carolina Division of Mental Health, Developmental Disabilities and Substance Abuse Services

Name: [Redacted] Date of Birth: [Redacted] Record #: [Redacted]  
 Medication: [Redacted] ISP Start Date: 10/14/2024

Current Living Situation	<input type="checkbox"/> Private Residence with family or natural supports: <input type="checkbox"/> Owned <input type="checkbox"/> Rented/Leased <input type="checkbox"/> Private Home alone or with a roommate (Supported Living): <input type="checkbox"/> Owned <input type="checkbox"/> Rented/Leased <input type="checkbox"/> Alternative Family Living/AFL Home ( <input type="checkbox"/> Unlicensed, <input type="checkbox"/> Licensed for __ beds) <input checked="" type="checkbox"/> Non-Private Residence (residence leased or owned by provider) ( <input type="checkbox"/> Unlicensed, <input checked="" type="checkbox"/> Licensed for 6 beds) <input type="checkbox"/> Other (describe):
Age/Graduation Status	<input checked="" type="checkbox"/> 22 or over <input type="checkbox"/> Under 22: <input type="checkbox"/> In School <input type="checkbox"/> Graduated with Diploma/GED – Date of Graduation: <input type="checkbox"/> Completed School with Certificate <input type="checkbox"/> Other:
Employment Status	<input type="checkbox"/> Student <input checked="" type="checkbox"/> Unemployed <input type="checkbox"/> Employed at or above Minimum Wage <input type="checkbox"/> Employer: <input type="checkbox"/> Average Hours worked per week:

Legally Responsible Person:  Self  Parent (minor child)  Legal Guardian  
 Other (describe):

Name: [Redacted]

Does the legally responsible person have advanced directives or estate planning documents regarding their wishes for a successor legally responsible person for the individual supported?  Yes  No

Does the legally responsible person live in the home with person supported?  Yes  No  
 (If no, provide address and phone # of legally responsible person below)

Address: [Redacted]

City, State, Zip: [Redacted]

Home Phone: [Redacted] Other Phone: [Redacted]

Cell Phone: [Redacted] Email: [Redacted]

Emergency Contact(s) in the event that the legally responsible person cannot be reached:

Name: [Redacted]	Phone: [Redacted]
Name: [Redacted]	Phone: [Redacted]

Participants in I/DD Development	
Name/Relationship	Name/Relationship
[Redacted], Mother	[Redacted], MGR/House of Care
[Redacted], QP/House of Care	[Redacted], IDD-CN/Alliance Health

**Alliance Health**

North Carolina Division of Mental Health, Developmental Disabilities and Substance Abuse Services

Name: [REDACTED] Date of Birth: [REDACTED] Record #: [REDACTED]  
 Medi: [REDACTED] ISP Start Date: 10/14/2024

Assessments/Reports Utilized in Plan Development (mark all that apply and attach to ISP)	
<input checked="" type="checkbox"/> Supports Intensity Scale™ (Scheduled)	<input checked="" type="checkbox"/> Risk/Support Needs Assessment (required)
<input type="checkbox"/> Person-Centered Planning Tool	<input checked="" type="checkbox"/> Behavior Support Plan
<input checked="" type="checkbox"/> Assessment of Outcomes and Supports	<input type="checkbox"/> Other (describe)

Diagnostic Information	
Code	Description
F84.0	Autistic Disorder

Back-Up Staffing Plan		
Agency-Directed Services OR Individual/Family Direction / Agency With Choice (AWC) Model	Who	Contact #
Agency Back-Up (mandatory)	[REDACTED]	[REDACTED]
Non-Paid Back-Up (in the event of an emergency)	[REDACTED]	[REDACTED]

Behavioral Supports Needed		
Behavior Support Plan is recommended if	Supports Intensity Scale / Behavioral Rating	98/5
<ul style="list-style-type: none"> <li>Rating is ≥ 13 for children (ages 21 and under)</li> <li>Rating is ≥ 10 for adults (ages 22 and over)</li> <li>Any individual identified as a Community Safety Risk based on self-injury or dangerousness to others</li> </ul>	Community Safety Risk based on self-injury or dangerousness to others?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

Status of Individual and Family Direction	
Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes, skip next three questions)	Currently using Individual/Family Direction <input type="checkbox"/> Agency with Choice <input type="checkbox"/> Employer of Record Services Self-Directed:
Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Orientation to Individual/Family Direction Given
Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Individual/Family Chose Not to Receive Orientation
Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Interested in Individual/Family Direction

**Care Coordination**

Your Care Coordinator can assist you in the following ways:

- Assisting you with assessment and documentation of your support needs.
- Assistance with development of your plan and Individual Budget.
- Monitoring services to ensure that you are receiving services to meet your needs and that you are happy with them.
- Monitoring to ensure that you are healthy and safe.
- Helping you receive information on directing your own services.
- Help you with problems or complaints about services, if necessary.

Care Coordination Monitoring Plan ( all that apply)

Alliance Health

North Carolina Division of Mental Health, Developmental Disabilities and Substance Abuse Services

Name: [Redacted] Date of Birth: [Redacted] Record ID: [Redacted] ISP Start Date: [Redacted] 2024

Minimum of monthly contact

Minimum of monthly face-to-face contact required for the following (Check All That Apply):

- Individuals living in residential placements, including alternative family living homes
- Individuals new to the waiver for the first six months
- Individuals who have service(s) provided by a guardian or relative living in the same home
- Individuals participating in Individual and Family Directed Services

Minimum of quarterly face-to-face contact with individual

Other \_\_\_\_\_

Signature Pages

**Innovations Waiver / Level of Care Re-Determination**

I certify that there has been no substantial change in the individual's condition and that the individual continues to require an ICF/IID Level of Care.

There has been a change in the individual's condition and the individual needs an ICF/IID assessment.

[Redacted Signature] \_\_\_\_\_ 10/12/2024 | 8:46:08 AM EDT  
 Signature of Care Coordinator Date

**Innovations Waiver / Freedom of Choice**

I understand that enrollment in the NC Innovations Waiver is strictly voluntary. I also understand that if I am determined to be ICFIID eligible, I will be receiving Waiver services instead of services in an ICF-IID (Intermediate Care Facility for Individuals with Intellectual Disabilities). I understand that in order to be determined to need waiver services, an individual must require the provision of at least one waiver service monthly and that failure to use a waiver service monthly will jeopardize my continued eligibility for the Innovations waiver.

I have chosen Innovations Waiver Services

I have not chosen Innovations Waiver Services

[Redacted Signature] \_\_\_\_\_ 10/12/2024 | 8:46:08 AM EDT  
 Signature of Individual or Legally Responsible Person Date

Choice in Residential Supports Statement

**Alliance Health**

North Carolina Division of Mental Health, Developmental  
Disabilities and Substance Abuse Services

Name: [Redacted] Date of Birth: [Redacted] Record: [Redacted]  
Medi: [Redacted] ISP Start Date: 10/14/2024

I live in a group home or AFL of my choice.

I live in a group home or AFL that I did not choose. Explain: \_\_\_\_\_

I live on my own.

I live with family or natural supports.

[Redacted Signature] \_\_\_\_\_ 10/12/2024 | 8:46:08 AM EDT  
 Signature of Individual or Legally Responsible Person Date

**Statement of Concern or Disagreement**

I, the individual/Legally Responsible Person signing this plan have concerns or disagree with the following issues related to my Individual Support Plan:

**Individual and/or Legally Responsible Person Signatures**

**Alliance Health**

North Carolina Division of Mental Health, Developmental  
Disabilities and Substance Abuse Services

Name [Redacted]  
Medicaid [Redacted]

Date of Birth: [Redacted]

Record [Redacted]  
ISP Start Date: 10/14/2024

By signing this plan, I am indicating agreement with the bulleted statements listed here unless crossed through. I understand that I can cross through any statement with which I disagree.

- My Care Coordinator helped me know what services are available.
- I was informed of the range of providers in my community qualified to provide the service(s) included in my plan and freely chose the providers who will be providing services/supports.
- This plan includes the services/supports I need.
- I participated in the development of this plan.
- I understand that Alliance Behavioral Healthcare will be coordinating my care with the Alliance Behavioral Healthcare network providers listed in this plan.
- I understand that all services under the Innovations Waiver, including Residential Supports and Supported Living, should be requested to the full extent of the individual's level of medical necessity; regardless of the individual's budgeting category.
- I understand that services may be authorized in excess of the Individualized Budget.

Signature of Individual  
[Redacted]

Date  
10/12/2024 | 8:46:08 AM EDT

Signature of Legally Responsible Person

Signed by  
[Redacted]

Date  
10/12/2024 | 8:46:08 AM EDT

Signature of Care Coordinator

Date

I acknowledge that I have received and reviewed the plan and attachments:

Signed by  
[Redacted]

10/17/2024 | 3:09:44 PM EDT

Signature of Qualified Professional / Agency Name

Date

Signature of Other Plan Participant / Agency Name

Date

Signature of Other Plan Participant / Agency Name

Date

Signature of Other Plan Participant / Agency Name

Date

Division of Health Service Regulation

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V 000	<p><b>INITIAL COMMENTS</b></p> <p>A complaint and follow up survey was completed on September 20, 2024. The complaints were unsubstantiated intake (#NC00220212 and #NC00221433). Deficiencies were cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disability.</p> <p>This facility is licensed for 5 and has a current census of 4. The survey sample consisted of audits of 2 current clients and 1 former client.</p>	V 000	V 112  Assessment/Treatment/Habilitation Plan	
V 112	<p>27G .0205 (C-D) Assessment/Treatment/Habilitation Plan</p> <p>10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN</p> <p>(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.</p> <p>(d) The plan shall include:</p> <ol style="list-style-type: none"> <li>(1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement;</li> <li>(2) strategies;</li> <li>(3) staff responsible;</li> <li>(4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both;</li> <li>(5) basis for evaluation or assessment of outcome achievement; and</li> <li>(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.</li> </ol>	V 112	<p>Effective 9/15/24, all treatment plans were reviewed. Training on each individual treatment goal was provided to all staff working in the home. The individual supervision needs were reviewed as well. As it relates to client #5 he was discharged prior to the survey. Client #4's treatment plan had been changed on 3/1/24. The plan which was approved by Alliance Health removed the need for one on one supervision after 3/1/24. The new plan did not reflect the change in level of supervision. That was an oversight by the entire team. Going forward the administrator/licensee will ensure that all updated treatment plans that address behavioral concerns or change in level of supervision are entered into the client's record within 72 hours. While waiting for the addendum (within that 72 hours) the QP will provide documentation of the change, provide training on the change to the administrator and staff and will place the updated treatment plan in the record within 72 hours of making any changes. The administrator/licensee will be responsible for making sure that the document is updated and shared with the group home.</p>	

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

*Clifford Thomas*

TITLE

*Licensee*

(X6) DATE

*10/18/2024*

STATE FORM

6899

2HG411

RECEIVED

If continuation sheet 1 of 15

OCT 21 2024

DHSR-MH Licensure Sect

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL092-411</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R-C 09/20/2024</b>
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NAME OF PROVIDER OR SUPPLIER  <b>THOMAS SUPERVISED CARE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>7016 BEAVERWOOD DRIVE RALEIGH, NC 27616</b>
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V 112	<p>Continued From page 1</p> <p>This Rule is not met as evidenced by: Based on observation, record review and interview the facility failed to implement 1 of 3 current client's treatment plan strategies (#4) and 1 of 1 former client's treatment plan strategies (FC#5). The findings are:</p> <p>A. Review on 9/12/24 of FC#5's record revealed:</p> <ul style="list-style-type: none"> <li>- admitted 5/13/20 &amp; discharged 7/20/24</li> <li>- diagnoses: Moderate Intellectual Disability, Impulse Control, Hypothyroidism and Thrombocytopenia</li> <li>- a treatment plan dated 3/1/24:</li> <li>- "...in January 2020 [FC#5] fell and broke his left arm...has not regained any significant uses of his left arm and is not expected that he will...has resulted in an increase in support needs to complete personal care and daily living task..."</li> <li>- "... [FC#5]'s increased stability is with 1:1 staffing...continues to exhibit physical and verbal aggression...individual staffing helps to address frustration at the time [FC#5] begins to experience and prevent escalation ...due to decrease in mobility and increase in age... need 1:1 staffing..."</li> <li>- "...[FC#5's] guardian prefers him to stay in his current placement due to its location...however as [FC#5]'s mobility declines and presence of stairs becomes an issue in the home (facility), the team is actively seeking new placement..."</li> </ul>	V 112		

Division of Health Service Regulation

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V 112	<p>Continued From page 2</p> <p>Observation on 9/12/24 at 11:58am of the facility revealed:</p> <ul style="list-style-type: none"> <li>- the facility was split level, it consisted of the following:</li> <li>- 5 stairs led to the downstairs area which consisted of: FC#5's and client #4's bedroom, a sitting area and bathroom</li> <li>- 7 stairs led to the upstairs area which consisted of the kitchen area, living room and bedrooms</li> </ul> <p>Review on 9/12/24 of the facility's incident reports for FC#5 revealed:</p> <ul style="list-style-type: none"> <li>- "3/28/24 at 4:30pm: staff prepared dinner heard thump in his (FC#5)'s room ...came downstairs, [FC#5] on floor &amp; bleeding in back of his head ...transported to ER (emergency room) ...received 3 sutures..."</li> <li>- "4/21/24 at 1pm: [FC#5] walked to bathroom without assistance ...staff went downstairs ... [FC#5] on commode with blood running downside of face. Blood came from spot he had sutures ...placed band aid on spot and monitored..."</li> <li>- "7/14/24 at 2:35pm:...said he fell out of bed and had a scratch on his temple with minimum blood ...staff cleaned spot ...no bruising"</li> <li>- "7/16/24 - complained of pain in shoulder and pain in his back. [staff #1/Licensee's son] called [Licensee]...[Licensee] looked at residents (FC#5's) arm and decided to transport [FC#5] to [hospital] ....resident arm was fractured..."</li> </ul> <p>Review on 9/13/24 of the local hospital discharge summaries for FC#5 revealed:</p> <ul style="list-style-type: none"> <li>- admitted &amp; discharged on 3/28/24 for a "mechanical fall"</li> <li>- "occipital scalp 1 centimeter laceration...will require closure"</li> <li>- "chief complaint: ...unsteady and patient</li> </ul>	V 112	<p>Going forward, all needs identified in the treatment plan will be addressed. Strategies, equipment, etc.. will be provided to the client as identified. If a client is to receive one on one then that service shall be provided as outlined and authorized by Alliance. And provided in a manner that meets that client's needs. At no time will staff be responsible for providing supervision to more than one client at a time if there is need for one on one supervision has been identified. At no time will more than one client be assigned to the same staff, if there is a need for one on one supervision identified in their treatment plan.</p> <p>The facility will continually assess its ability to provide services to clients as identified in referral, contract, ongoing assessments and provide the specified level of care at all times.</p>	
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V 112	<p>Continued From page 3</p> <p>(FC#5) got up without assistance and hit his head against the door frame ...per group home staff...patient stumbled and fell into doorway...no report of loss of conscious ...no pain complaints, shortness of breath..."</p> <ul style="list-style-type: none"> <li>- admitted &amp; discharged on 7/16/24:</li> <li>- "chief complaint in triage ...patient wheeled to triage with complaints of right shoulder pain/injury, patient also has abrasion to right side of cheek, right knee and bruising to right outer ankle...had a fall on Sunday...large bruise noted to right shoulder upper arm ...able to move extremities equally ...patient does not remember ...fall was not witnessed. He managed to get himself up after the fall but staff noted some abrasions to the face and knees and subsequently determined that he had fallen...group home staff looked at his shoulder today (7/16/24) and noticed significant swelling and bruising ...no headaches...show a proximal humerus fracture with no underlying dislocation ...orthopedic advised a sling ..."</li> </ul> <p>During interview on 9/12/24 client #2 reported:</p> <ul style="list-style-type: none"> <li>- he recalled the 7/14/24 incident</li> <li>- he and staff #5 were upstairs and heard a thump downstairs</li> <li>- they went downstairs and found FC#5 beside his bed</li> <li>- FC#5 said he fell and did not say anything else</li> <li>- did not see 1:1 staff with FC#5</li> <li>- if staff #1/Licensee's son was 1:1 staff, he would leave work "right" at 12pm</li> </ul> <p>During interview on 9/18/24 staff #5 reported:</p> <ul style="list-style-type: none"> <li>- worked the weekend shift from Friday 8pm - Sunday 8pm</li> <li>- no 1:1 staff on the weekends</li> <li>- worked with all the clients</li> </ul>	V 112		

Division of Health Service Regulation

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V 112	<p>Continued From page 4</p> <ul style="list-style-type: none"> <li>- recalled 1 time in 2024 FC#5 fell in the bathroom</li> <li>- he was upstairs and heard a fall downstairs</li> <li>- FC#5 had fallen in the bathroom</li> <li>- a little blood dripped down FC#5's face and he applied first aid</li> <li>- he was upstairs during the 7/14/24 incident</li> <li>- FC#5 came upstairs and said he fell and bumped his head</li> <li>- he saw a little blood on his head, and applied first aid</li> <li>- FC#5 went on an outing and had no further complaints on 7/14/24</li> <li>- he assisted FC#5 that night (7/14/24) with his pajamas and there were no bruises or complaints from FC#5</li> <li>- he made staff #3 aware of the fall and requested staff #3 monitor FC#5</li> </ul> <p>During interview on 9/18/24 staff #3 reported:</p> <ul style="list-style-type: none"> <li>- on 7/14/24, he worked 8pm - 8am the next day (7/15/24)</li> <li>- FC#5 was in the bed when he arrived on 7/14/24</li> <li>- no complaints from FC#5 on his shift</li> </ul> <p>During interview on 9/16/24 staff #1/Licensee's son reported:</p> <ul style="list-style-type: none"> <li>- worked 8am - 12pm Monday - Friday, no weekends</li> <li>- he became FC#5's 1:1 in February 2024 or March 2024</li> <li>- from 12pm - 3pm he was the 1:1 for FC#5</li> <li>- no incidents of falls when FC#5 was in his care</li> <li>- FC#5 had a walker to use in the facility and in the community</li> <li>- he came to work on 7/15/24 and FC#5 complained of some shoulder pain</li> <li>- on 7/16/24 FC#5 had "low energy" and when</li> </ul>	V 112		

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V 112	<p>Continued From page 5</p> <p>he touched his shoulder to assist him upstairs for breakfast, he complained of shoulder pain. He called the Licensee</p> <ul style="list-style-type: none"> <li>- the Licensee transported FC#5 to the emergency room</li> </ul> <p>During interview on 9/18/24 FC#5's Care Manager with the Local Management Entity/Managed Care Organization (LME/MCO) reported:</p> <ul style="list-style-type: none"> <li>- was FC#5's Care Manager since October 2023</li> <li>- FC#5 was supposed to have 1:1 staff during awake hours Monday - Sunday</li> <li>- staff #1/Licensee's son was FC#5's 1:1 staff</li> <li>- he (Care Manager) made announced visits to the facility and staff #1/Licensee's son was present with FC#5 and at times, other clients were present with only staff #1/Licensee</li> <li>- was not aware FC#5 did not have 1:1 staff on the weekends</li> <li>- "that doesn't make sense not to have a 1:1 on the weekends"</li> <li>- FC#5 needed assistance daily due to limitations with his left arm and limited mobility</li> </ul> <p>During interview on 9/20/24 the Licensee reported:</p> <ul style="list-style-type: none"> <li>- FC#5 had 1:1 staff from 8am - 8pm Monday - Friday by his son (staff #1/Licensee's son)</li> <li>- no 1:1 weekend staff for FC#5</li> <li>- the LME/MCO cut funding for the weekend staff</li> <li>- he could not recall when the funds were cut but planned to reach out to his case management office to find out</li> <li>- had informed the Care Manager during each monthly visit, FC#5 needed a higher level of care due to the decline in his mobility</li> </ul>	V 112		

Division of Health Service Regulation

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V 112	<p>Continued From page 6</p> <p>B. Review on 9/12/24 of client #4's record revealed:</p> <ul style="list-style-type: none"> <li>- admitted June 2020</li> <li>- diagnosis: Autism</li> <li>- treatment plan dated 3/1/24:</li> </ul> <p>"...nonverbal...requires 1:1 staff during all awake hours...he can go from agitation to aggression quickly and will do the following: charge staff, make loud noises, bang on mirrors, jump up and down, break personal items, push against staff and scream..."</p> <p>Observation on 9/12/24 of client #4 revealed no 1:1 staff present at the following times:</p> <ul style="list-style-type: none"> <li>- 11:42am: staff #1/Licensee's son present with client #2 &amp; client #4</li> <li>- 11:58am: client #4 sat on his bed and listened to his iPad</li> <li>- 12:25pm: staff #4 arrived and staff #1/Licensee's son left</li> <li>- 3:02pm: client #4 came out his bedroom and charged at client #2. Client #2 held his fist out and bumped fist client #4. Client #4 fist bumped fist client #2 and returned to his bedroom. Client #4 laughed loudly in his bedroom</li> </ul> <p>Observation on 9/16/24 of client #4 revealed no 1:1 staff present at the following times:</p> <ul style="list-style-type: none"> <li>- 12pm - 2:28pm - client #4 remained in his bedroom and his iPad played loudly</li> <li>- 12:07pm - staff #1/Licensee's son left and staff #2 arrived at the facility and was present with client #2 &amp; #4</li> <li>- 2:02pm: staff #2 walked in client #4's bedroom briefly and left out</li> <li>- 3:15pm: client #4 made loud noises in his bedroom</li> <li>- 3:22pm - client #4 left out of the bathroom and clapped his hands loudly as he returned to his bedroom</li> </ul>	V 112		

Division of Health Service Regulation

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V 112	<p>Continued From page 7</p> <p>During interview on 9/16/24 staff #2 reported:</p> <ul style="list-style-type: none"> <li>- worked Monday - Friday with times varying from either 9am - 3pm or 12pm - 4pm</li> <li>- he was the 1:1 for client #4 however there were times "I worked alone with [clients #1 - #2] &amp; [ FC#5]"</li> </ul> <p>During interview on 9/16/24 the Licensee reported:</p> <ul style="list-style-type: none"> <li>- was aware client #4 did not have 1:1 staff at times</li> <li>- was in the process of hiring additional staff to meet client #4's needs</li> </ul> <p>Review on 9/20/24 of the Plan of Protection dated 9/20/24 written by the Licensee revealed:</p> <ul style="list-style-type: none"> <li>- "What immediate action will the facility take to ensure the safety of the consumers in your care? All consumers who are in need of one on one staff will from this day Sept. (September) 20, 2024 will receive one on one staffing. Presently there are one on one staff available to provide this service. Will go through all updated plans to make sure all residents needs or goals are being met for there safety and progress."</li> <li>- "Describe your plans to maker sure the above happens. I will be on duty as a one on one staff until interviews are finished for hired staff. Staff will be hired on or before next week and start on 9/30/24. There will be 2 staff on at all times to cover the one on one."</li> </ul> <p>This deficiency constitutes a re-cited deficiency.</p> <p>Clients were admitted to the facility with diagnoses of Moderate Intellectual Disability, Impulse Control and Autism. Client #4 and FC#5's treatment plans documented they needed 1:1 staff daily to meet behavioral needs and</p>	V 112		

Division of Health Service Regulation

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V 112	Continued From page 8  FC#5's mobility issues. The 1:1 staff assigned to client #4 and FC#5 worked alone with 4 other clients in the facility. There were no 1:1 staff for client #4 and FC#5 on the weekends. FC#5 fell on 2 different occasions during weekend shifts. On March 28, 2024, the staff was upstairs, and FC#5 fell downstairs hitting his head which resulted in 3 sutures. On July 14, 2024, the staff was upstairs, and FC#5 fell downstairs resulting in a humerus fracture to the right arm. On 9/12/24 and 9/16/24, client #4 was observed at least 9 times without a 1:1 staff an attempted on one occasion to charge at client #2. The Licensee was aware at times client #4 and FC#5 did not have 1:1 staffing. This deficiency constitutes a Type A1 rule violation for serious neglect and must be corrected within 23 days.	V 112		
V 289	27G .5601 Supervised Living - Scope  10A NCAC 27G .5601 SCOPE (a) Supervised living is a 24-hour facility which provides residential services to individuals in a home environment where the primary purpose of these services is the care, habilitation or rehabilitation of individuals who have a mental illness, a developmental disability or disabilities, or a substance abuse disorder, and who require supervision when in the residence. (b) A supervised living facility shall be licensed if the facility serves either: (1) one or more minor clients; or (2) two or more adult clients. Minor and adult clients shall not reside in the same facility. (c) Each supervised living facility shall be licensed to serve a specific population as designated below: (1) "A" designation means a facility which	V 289	V289 Supervised Living – Scope  The facility is not the primary residence for the administrator/licensee. Staff are assigned for shifts and are not assigned as live in staff. At no time will a staff use this as their designated personal residence.	

Division of Health Service Regulation

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V 289	<p>Continued From page 9</p> <p>serves adults whose primary diagnosis is mental illness but may also have other diagnoses;</p> <p>(2) "B" designation means a facility which serves minors whose primary diagnosis is a developmental disability but may also have other diagnoses;</p> <p>(3) "C" designation means a facility which serves adults whose primary diagnosis is a developmental disability but may also have other diagnoses;</p> <p>(4) "D" designation means a facility which serves minors whose primary diagnosis is substance abuse dependency but may also have other diagnoses;</p> <p>(5) "E" designation means a facility which serves adults whose primary diagnosis is substance abuse dependency but may also have other diagnoses; or</p> <p>(6) "F" designation means a facility in a private residence, which serves no more than three adult clients whose primary diagnoses is mental illness but may also have other disabilities, or three adult clients or three minor clients whose primary diagnoses is developmental disabilities but may also have other disabilities who live with a family and the family provides the service. This facility shall be exempt from the following rules: 10A NCAC 27G .0201 (a)(1),(2),(3),(4),(5)(A)&amp;(B); (6); (7) (A),(B),(E),(F),(G),(H); (8); (11); (13); (15); (16); (18) and (b); 10A NCAC 27G .0202(a),(d),(g)(1) (i); 10A NCAC 27G .0203; 10A NCAC 27G .0205 (a),(b); 10A NCAC 27G .0207 (b),(c); 10A NCAC 27G .0208 (b),(e); 10A NCAC 27G .0209[(c)(1) - non-prescription medications only] (d)(2),(4); (e) (1)(A),(D),(E);(f);(g); and 10A NCAC 27G .0304 (b)(2),(d)(4). This facility shall also be known as alternative family living or assisted family living (AFL).</p>	V 289		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL092-411</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>R-C 09/20/2024</b>
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NAME OF PROVIDER OR SUPPLIER  <b>THOMAS SUPERVISED CARE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>7016 BEAVERWOOD DRIVE RALEIGH, NC 27616</b>
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(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 289	<p>Continued From page 10</p> <p>This Rule is not met as evidenced by: Based on observation and interview the facility failed to provide residential services to individuals in a home environment where the primary purpose of these services is the care, habilitation or rehabilitation of individuals who have developmental disabilities for 4 of 4 current clients and 1 of 1 discharge client (FC#4). The findings are:</p> <p>Observation on 9/12/24 at 11:58pm of the facility revealed:</p> <ul style="list-style-type: none"> <li>- the staff bedroom had clothes on the bed and miscellaneous items on dresser</li> </ul> <p>During interview on 9/16/24 the Licensee reported:</p> <ul style="list-style-type: none"> <li>- the facility was his personal resident</li> <li>- he received mail at the facility</li> <li>- he lived at the facility</li> </ul>	V 289		
V 367	<p>27G .0604 Incident Reporting Requirements</p> <p>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</p>	V 367		