STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL078-330	A. BUILDING: _____ B. WING _____	10/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILKINSON FACILITY	635 NORTH WILKINSON DRIVE SAINT PAULS, NC 28384

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V 000	INITIAL COMMENTS A complaint survey was completed on October 23, 2024. One complaint was unsubstantiated (intake #NC00223338) and two complaints were substantiated (intake #'s NC00223200 and NC00222234). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600B Supervised Living for Minors with Developmental Disabilities. This facility is licensed for 4 and has a current census of 2. The survey sample consisted of audits of 2 current clients and 1 former clients.	V 000		
V 291	27G .5603 Supervised Living - Operations 10A NCAC 27G .5603 OPERATIONS (a) Capacity. A facility shall serve no more than six clients when the clients have mental illness or developmental disabilities. Any facility licensed on June 15, 2001, and providing services to more than six clients at that time, may continue to provide services at no more than the facility's licensed capacity. (b) Service Coordination. Coordination shall be maintained between the facility operator and the qualified professionals who are responsible for treatment/habilitation or case management. (c) Participation of the Family or Legally Responsible Person. Each client shall be provided the opportunity to maintain an ongoing relationship with her or his family through such means as visits to the facility and visits outside the facility. Reports shall be submitted at least annually to the parent of a minor resident, or the legally responsible person of an adult resident. Reports may be in writing or take the form of a conference and shall focus on the client's progress toward meeting individual goals.	V 291		

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V 291	Continued From page 1 (d) Program Activities. Each client shall have activity opportunities based on her/his choices, needs and the treatment/habilitation plan. Activities shall be designed to foster community inclusion. Choices may be limited when the court or legal system is involved or when health or safety issues become a primary concern. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to maintain coordination between the agencies, individual and the qualified professionals who are responsible for the client's treatment, affecting one of three audited clients (Former Client (FC) #3). The findings are: Finding #1: Review on 10/23/24 of FC #3's record revealed: -Admission date of 7/12/24. -Diagnoses of Moderate Intellectual Disabilities; Autism Disorder; Bipolar Disorder, Tremors; Post Traumatic Stress Disorder; Attention Deficit Hyperactivity Disorder. General Event Reports: Reported by [Staff #1] "Event date 10/21/24. Summary- Consumer was talking to his rbt (Registered Behavior Technician) outside and while they were walking he stated he was going to hit his rbt with a stick...consumer started running away from home staff calmed him down enough to come back home but when i used the restroom and came back out was stabbing wall with screw driver i tried to disarm consumer but he was trying to stab me so i put him in a theruputic hold but he was starching and biting me and trying to head but me other staff called 911 and when they arrived he became more erractic and threatened other staff so police	V 291		

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V 291	Continued From page 2 handcuffed him and took him to hospital." Interview on 10/23/24 FC #3's guardian stated: -The facility had not made her aware of all FC #3's hospital visits. -She learned FC #3 had hospital visits on 10/10/24, 10/14/24, 10/17/24, 10/18/24 and 10/24/24. -The facility had only contacted her on 10/14/24. -She learned about the other hospital visits from the hospital or local law enforcement. -She had requested hospital discharge records from the facility and had not received the hospital discharge records. -She had also requested incident reports for details that lead to hospitalizations and only received two incident reports. Interview on 10/23/24 the local behavioral health hospital staff stated: -She told the facility staff and FC #3's guardian that the hospital is not an adolescent unit and they do not handle placement of patients. -The behavioral health hospital is not a part of 30-day notices given to clients. -On 10/10/24, 10/11/24, 10/21/24 an 10/22/24 FC #3 had been left at the hospital and when he was cleared from the medical and psychiatry units at the hospital and she was unable to reach anyone by phone for him to be picked up. -On 10/11/24 she was able to reach the Qualified Professional (QP) at 8:10am after his 10/10/24 visit to the hospital for FC #3 to be picked up. -The hospital had not employed sitters to sit outside a patients room. -On 10/22/24 FC #3 was sent back to the facility with a local officer after she spoke with FC #3's guardian. Interview on 10/23/24 the House Manager stated:	V 291		

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V 291	Continued From page 3 -She had taken FC #3 to the hospital for a behavior issue. -She had contacted the QP and FC #3's guardian. -FC #3 was not admitted and was in a private room. -While at the hospital, she went to the vending machine and a sitter was outside FC #3's door. Interview on 10/23/24 the QP stated: -She had initiated a 60 day discharge notice on 10/20/24 then a 30-day discharge notice for FC #3 on 10/21/24 and notified the guardian. -The hospital called on 10/22/24 to have FC #3 picked up and she told them they would have to call FC #3's guardian because he was discharged from the facility. -FC #3's guardian told her that she would pick up FC #3 from the hospital on 10/22/24. -When a client had been taken to the hospital, the staff waited until all paperwork is completed before leaving the hospital. -She was not aware of any complaints about staff not staying at the hospital with FC #3. -She did not know the behavioral health hospital FC #3 had been taken to did not do admissions.	V 291		
V 736	27G .0303(c) Facility and Grounds Maintenance 10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS (c) Each facility and its grounds shall be maintained in a safe, clean, attractive and orderly manner and shall be kept free from offensive odor. This Rule is not met as evidenced by: Based on observation and interview the facility was not maintained in a clean, attractive and	V 736		

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V 736	Continued From page 4 orderly manner. The findings are: Observation on 10/23/24 at approximately 10:25am revealed: -The stair rails leading to the downstairs area was loose on both sides. -The left stair rail leading upstairs was loose and missing a connector to the wall. -Former Client (FC) #3's bedroom had a blue substance smeared on the floor; clothing was scattered throughout the floor; the closet light fixture did not have a globe. -The first client bedroom on the left had 3 holes of different sizes next to the bed rail. There was no mattress on the bed. The right window screen was torn. The connected bathroom had broken and loose tiles on the floor that were soft to the step/touch. -Client #1's bedroom left side closet door was off track. -Client #3 had an approximately 3 inch hole on the side of his closet; the right side closet door was missing; the left side closet door was missing the knob; clothing was on the floor; 3 dresser drawers were sitting on the floor; multiple holes about the size of a screw were in the walls throughout the room; the smoke alarm was hanging from the ceiling approximately 1-2 inches; a gray comforter was on the floor of the closet. -The first hall bathroom on the right was missing 2 of 4 bulbs. The door handle did not latch and was missing the latch piece. -The second hall bathroom's door was not latching; 6 bulb light fixture was missing one bulb and non worked when switch turn in on position. -The hall closet upstairs had no knob. -The medication room had peeling around the door frame inside the room; brown stains on the wall by the light switch; brown stains on the wall	V 736		

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V 736	Continued From page 5 on the left side of the room; stacks of wood on the floor by the slide door. There were 3 light fixtures missing covers -The hallway ceiling had an approximate 3 foot by 3 foot square shaped area that was discolored with dark residue. Interview on 10/23/24 the Qualified Professional stated: -There had been a leak in the ceiling from the air conditioning unit. It had been fixed and it had to dry out before the inside ceiling could be replaced. It had been like that for a few months and fixed several times.	V 736		

Findings	Corrective Measures	Preventive Measures	Responsible Party/ How often	Time Frame
10A NCAC 27G . 5603 Supervised Living Operations	Guardian was made aware of every incident, hospital visits, and sent incident reports. Majority calls were left on voicemail due to guardian refusal to answer phone calls and follow up emails were sent every time	Continued communication with all involved parties	QP House manager	60 days
10A NCAC 27G . 0303 Location and exterior requirements	Work is in process of being completed	Work orders are completed as soon as damage occurs. Depending on the work that has to be completed, it may take longer than the two weeks that is allotted, per our policy on property damage	House manager Admin Staff	60 days