Division of Health Service Regulation

STATEMENT OF DEFICIENCIES

	F DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPI A. BUILDING	(X3) DATE SURVEY COMPLETED		
MHL0601541		MHI 0601541	B. WING			
JAME OF BE	ROVIDER OR SUPPLIER				04/08/202	
VAIVIE OF FF	NOVIDER OR SUPPLIER		ADDRESS, CITY, ST			
BRENDA C	GIBSON HOME		SHLEY CREEK D EWS, NC 28105			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID.	PROVIDER'S PLAN OF CORRECTION	. (
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	FIX (EACH CORRECTIVE ACTION SHOULD BE		
V 108	This facility is licensed category: 10A NCAC Living for Alternative for Altern	d for the following service 27G .5600F Supervised family Living. d for 2 and has a current ey sample consisted of ents. ennel Requirements PERSONNEL ion shall be documented. In programs shall be himum, shall consist of the ional orientation; rights and confidentiality as AC 27C, 27D, 27E, 27F and the me treatment/habilitation was diseases and in the facility at all present. That staff ed in basic first aid agement, currently trained onary resuscitation and maneuver or other first aid ose provided by Red Cross,	V 108	Provider completed First Aid training 4/14/25. Training documents can be provided if necessary. The Human Resources Director maintains ongoing required trainings for staff. Deficient has been resolved as of 4/14/25.	oing	
	he American Heart As					
The same of the sa	equivalence for relieving	ng airway obstruction.				
	h Service Regulation RECTOR'S OR PROVIDER/SU	IPPLIER REPRESENTATIVE'S SIGNATURE Amber Highsmit	The same of the sa	TITLE	(X6) DATE	
FORM	-			QMD 0	4/17/2025	

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL0601541	B. WING		04	1/08/2025
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1200 ASHLEY CREEK DRIVE MATTHEWS, NC 28105						100/2020
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
	27E .0107 Client Righ Int. 10A NCAC 27E .0107 ALTERNATIVES TO RINTERVENTIONS (a) Facilities shall imp practices that emphasis to restrictive intervention (b) Prior to providing signification of the strategies for crewhich the likelihood of or injury to a person with property damage is present of the strategies for crewhich the likelihood of or injury to a person with property damage is present of the strategies for crewhich the likelihood of or injury to a person with property damage is present of the strategies for crewhich the likelihood of or injury to a person with property damage is present of the compliance and demongathered. (d) The training shall be include measurable least measurable testing (write behavior) on those object methods to determine procurse. (e) Formal refresher training provider wishes to employ the Division of MH/DD/S Paragraph (g) of this Russian (g) Staff shall demonstrate following core areas:	TRAINING ON RESTRICTIVE Ilement policies and lize the use of alternatives ons. Services to people with ling service providers, revolunteers, shall lince by successfully communication skills and lating an environment in imminent danger of abuse the disabilities or others or evented. In the shall establish training lencies, monitor for internal lastrate they acted on data are competency-based, rning objectives, litten and by observation of ectives and measurable chassing or failing the laining must be completed are periodically (minimum ling that the service loy must be approved by SAS pursuant to alle.	V 536 V 536	Provider received updated NCI train on 4/15/25. Proof of training can be provided if necessary. The Human Resources Director maintains ongo required trainings for staff. HR Director also holds NCI training every Tueso This deficiency was resolved on 4/1	oing ector day.	4/15/25

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	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	LE CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		MHL0601541	B. WING		04	/08/2025
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, ST	32:10F3M:::31.9 53:50TVTB		
BRENDA	GIBSON HOME		VS, NC 28105			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
V 536	by scoring a passing of instructor training progressions of the passing of instructor training progressions of the passing of instructor training progressions of the passing observation of behavior measurable methods to the failing the course. (4) The content of service provider plans approved by the Division to Subparagraph (i)(5) (5) Acceptable in shall include but are not passing to the passing progression of the progression of the passing progr	grade on testing in an aram. shall be clude measurable learning at testing (written and by or) on those objectives and o determine passing or of the instructor training the to employ shall be on of MH/DD/SAS pursuant of this Rule. Instructor training programs of limited to presentation of: go the adult learner; deaching content of the evaluating trainee In procedures. In have coached experience gram aimed at preventing, go the need for restrictive me time, with positive It teach a training program ducing and eliminating the eventions at least once complete a refresher st every two years. It is all maintain and refresher instructor every eyears. It is all maintain and the ere attended; and	V 536			

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MML0601541 B. WING MML0601541 B. WING MML0601541 AND MML0601541 MML0601	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1200 ASHLEY CREEK DRIVE MATTHEWS, NC 28105 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) V 536 Continued From page 6 training in alternatives to restrictive interventions. Interview on 4/8/25 with the Quality Management Director revealed: -The facility was currently using NCI (Nonviolent Crisis Intervention) training to meet the requirement of training in alternatives to restrictive interventions.								
BRENDA GIBSON HOME 1200 ASHLEY CREEK DRIVE MATTHEWS, NC 28105 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) V 536 Continued From page 6 training in alternatives to restrictive interventions. Interview on 4/8/25 with the Quality Management Director revealed: -The facility was currently using NCI (Nonviolent Crisis Intervention) training in alternatives to restrictive to restrictive interventions.			MHL0601541	B. WING			4/08/2025	
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	V 536	training in alternatives Interview on 4/8/25 with Director revealed: -The facility was curre Crisis Intervention) training restrictive interventions	to restrictive interventions. th the Quality Management ntly using NCI (Nonviolent ining to meet the g in alternatives to s.	V 536				

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