Division of Health Service Regulation

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SU COMPLE	
,	5. GG.W.EG.WG.	is a transfer to the state of t	A. BUILDING: _			
		MHL080-166	B. WING		05/22	2/2025
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
CABARRI	JS COUNTY GROUP HO	ME 7	ROCK DRIVE RY, NC 28144			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECTIO	N	(X5)
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)		COMPLETE DATE
V 000	INITIAL COMMENTS		V 000			
	An annual survey was Deficiencies were cite	s completed on 5/22/25. ed.				
		d for the following category: OC Supervised Living for nental Disability.				
	_	d for 5 and has a current yey sample consisted of ents.				
V 118	27G .0209 (C) Medic	ation Requirements	V 118			
	only be administered order of a person aut drugs.  (2) Medications shall clients only when aut client's physician.  (3) Medications, incluadministered only by unlicensed persons to the pharmacist or other leprivileged to prepare  (4) A Medication Admall drugs administered current. Medications recorded immediately MAR is to include the (A) client's name;  (B) name, strength, and (C) instructions for according to the contraction of the contraction	istration: n-prescription drugs shall to a client on the written horized by law to prescribe  be self-administered by horized in writing by the  ding injections, shall be licensed persons, or by rained by a registered nurse, egally qualified person and and administer medications. hinistration Record (MAR) of d to each client must be kept administered shall be or after administration. The er following:				

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

(X6) DATE TITLE

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL080-166	B. WING		05/22/2025
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	ZIP CODE	,
CABARRI	US COUNTY GROUP HO	MF 7 125 SHA	MROCK DRIVE		
OADAM	T	SALISBU	JRY, NC 28144		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETE
V 118	Continued From page	<del>:</del> 1	V 118		
	checks shall be recor	r medication changes or ded and kept with the MAR pointment or consultation			
	facility failed to ensur administered on a wri authorized by law to p failed to keep current	ew and interviews, the e medications were tten order of a person prescribe medications and the MAR for all drugs g one of three audited			
	-Date of admission: 7 -Diagnoses: Mild Inte Disease; Sebhona of and Legs; Previous A Stenosis/Aortic Insuff Impairment; Bicuspid -Client is his own gua -Physician-ordered m 7/24/24 Pantoprazole	llectual Disability; Crohn's Scalp; Psoriasis of Arms nemia; Aortic iciency; Left Ear Aortic Valve; Aortic Dilation. rdian.			
	and April 2025 MARs -Pantoprazole was cr handwritten line using 3/2/25 at 8pm.	ossed through with g black ink, 2/3/25 through ot initials as administered on			

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		MHL080-166	B. WING		05/22/2025
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STAT	TE, ZIP CODE	
CARADDI	IC COUNTY OROUR HOL	125 SHA	MROCK DRIVE		
CABARRI	JS COUNTY GROUP HO	SALISBU	IRY, NC 28144		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE
V 118	Continued From page	2	V 118		
V 118	-Pantoprazole was inicrossed out with hand through 3/26/25 at 8p -Pantoprazole was not 4/3/25 through 4/9/25 4/27/25 at 8pm.  Interview on 5/21/25 v-Never missed or refurbations on time.  Interview on 5/19/25 v-Taken medications on time.  Interview on 5/19/25 v-Cross out on MAR w-Was trained to admirus trained to ad	tial by Staff #2 and then dwritten black ink, 3/20/25 m. It initials as administered on and 4/17/25 through  with client #2 revealed: seed his medications. aily and staff gave  with Staff #1 revealed: as usually an error. Inster medications. alized (4/24/25 through ated to Crohn's disease. If #2 was confused about 2's Pantoprazole. It was a point doctors) had took him (client at night time and he got put ome communication errors	V 118		
	"between the office (L doctor, and his mothe -"We'll (facility) get the	s of poor communication icensee) and his (client #2) rr." e word (medical information) other and not the [Primary			
		are needed to communicate			

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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		, , ,	(X3) DATE SURVEY COMPLETED	
	MHL080-166	B. WING		0.5	5/22/2025	
NAME OF PROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE	, 3	·	
	125 SHA	MROCK DRIVE				
CABARRUS COUNTY GROUP HOME	7	IRY, NC 28144				
PREFIX (EACH DEFICIENCY M	MENT OF DEFICIENCIES JUST BE PRECEDED BY FULL DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE)	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
paperwork from the [Prir Saturday (5/17/25) she (like, 'don't give him the F-"but with this particular Pantoprazole, I made stoclarity), confirmed that he taking it (Pantoprazole) a #2] and I think that's why initializing or putting nother -Did no follow directives administration from client what's written on the MA we're supposed to do."  Interview on 5/21/25 with -Was trained to administ -Was not aware that client his medicationsClient #2 had been "have whiledoctor will hold hist They (provider) switched times a day to one time a (administration)within the least" -Group home managers writing any changes on the manager coming in will the what's going onChanges in administration been made by client #2's he was only supposed to was under the impression supposed to be getting (	vas his own guardian. (client #2) Prednisone If 3 or 4 times, it ins) will be on the release mary provider]; last (client #2's mother) was Prednisone."  ar confusion for the ure I asked (mother for the (client #2) was still and passed it on to [Staff ty he (Staff #2) wasn't thing on there (MAR)." on medication int #2's mother; "I go by AR, because that's what  AR, because that's what  AR the Staff #2 revealed: the medications. The staff #2 revealed: The medications what  I are responsible for the MAR so that the next the MAR so that the next the medication it and know  I are responsible for The MAR so that the next the mare responsible for The MAR so that the next the	V 118				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		MHL080-166	B. WING		05/22/2025	5
	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA ROCK DRIVE RY, NC 28144	TE, ZIP CODE	,	<u>'</u>
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMP	PLETE
V 118	-Client #2's mother of and provides updates doctor because she's (facility) the paperwo tells usClient #2's health sta often"Following his (client keep up with the charmedication)." -Going forward will for Interview on 5/16/25 Assistant (OA) revea -She was responsible keeping up with clien from the pharmacy are. Was not aware clien Pantoprazole administriction of the pharmacy are. "[Staff #2] must have sure; I'll have to ask Ire." Sometimes his (client tells them (staff) to he Pantoprazole) if his or go by the mother's recone in contact with [Findoctor."  Interview on 5/19/25 Professional revealed -Was not aware of comedication (Pantoprazole) if his or go by the mother's recone in contact with [Findoctor."	ommunicates with doctors is to staff. "She gets with the sa nurse, she gives us rk and verbal notes that she atus and medications change it #2) MAR, is the best way to nge (administration of onge onge) with the Office led:  If or getting doctor orders, it medications, getting MARs on the office of onge of onge of onge of onge. I'm not one of onge o	V 118			

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administration for client #2.

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL080-166	B. WING		05/22/20	25
NAME OF P	ROVIDER OR SUPPLIER		RESS, CITY, STA ROCK DRIVE	TE, ZIP CODE		
CABARRI	JS COUNTY GROUP HO	ME 7	Y, NC 28144			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE CO	(X5) MPLETE DATE
V 118	makes suggestions of (facility) need to be ta #2]'s doctors to get up	gets overly involved and n the medications, but we lking directly with [Client odates and changes with his ed to follow the doctor orders	V 118			
V 131	Verification  G.S. §131E-256 HEAREGISTRY (d2) Before hiring heath care facility or health care facility sha	ACPR - Prior Employment  LTH CARE PERSONNEL  Alth care personnel into a service, every employer at a all access the Health Care and shall note each incident opriate business files.	V 131			
	failed to ensure the H Registry (HCPR) was employment affecting The findings are:  Review on 5/15/25 of revealed: -Date of hire was 8/14 -HCPR was accessed	ew and interview, the facility ealth Care Personnel accessed prior to two of two staff (#1, #2).  Staff #1's personnel record  4/07.  18/24/07.				
	Review on 5/15/25 of revealed: -Date of hire was 8/4/	Staff #2's personnel record  20.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	(X3) DATE SURVEY		
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
		MHL080-166	B. WING		05/22/2025
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE	
CARARPI	JS COUNTY GROUP HOI	ME 7	IROCK DRIVE		
CABARRO	3 COUNTY GROUP HO	SALISBU	RY, NC 28144		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
V 131	Continued From page	e 6	V 131		
	-HCPR was accessed	1 8/14/20.			
	(AS) #3 revealed: -Shared the responsil with AS#4There had been som retirement) in staff as -There was confusion verification should be -Was not aware the hprior to employment.  Interview on 5/21/25 shared the responsil with AS#3There had been som retirement) in staff as -There was confusion verification should be	assessed. ICPR should be accessed with the AS #4 revealed: bility of accessing the HCPR are changes (resignation, signed to access the HCPR. a on when the HCPR			
	to access the HCPR a weren't being done co -Had reassigned the to other staff (AS#3, AS problem going forwar	d: overseeing the hiring istrative staff (AS#3, AS#4) and "we found out they orrectly" task of accessing HCPR to #5), "so that shouldn't be a d." CPR is requested prior to			
V 133	G.S. 122C-80 Crimina	al History Record Check	V 133		
	G.S. §122C-80 CRIM	INAL HISTORY RECORD			

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	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		MHL080-166	B. WING		05/2	2/2025
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
CABARRI	JS COUNTY GROUP HO	NE 7	ROCK DRIVE Y, NC 28144			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y 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
V 133	"provider" applies to a program and any providevelopmental disabil services that is licens Chapter.  (b) Requirement An provider licensed und applicant to fill a positi applicant to have an acconditioned on consecriminal history record the applicant has bee less than five years, t is conditioned on conscriminal history record national criminal history record section. Except as other subsection, within five the conditional offer of shall submit a request Justice under G.S. 11 criminal history record section or shall submit entity to conduct a Stacheck required by this G.S. 114-19.10, the Direturn the results of new providers in the security of the conditional offer of section or shall submit and the conditional offer of shall submit a request Justice under G.S. 11 criminal history record section or shall submit and the conditional offer of shall submit a request Justice under G.S. 11 criminal history record section or shall submit and the conditional offer of shall submit a request Justice under G.S. 11 criminal history record section or shall submit and the conditional offer of shall submit a request Justice under G.S. 11 criminal history record section or shall submit and the conditional offer of shall submit and the c	FOR CERTAIN MPLOYMENT.  ed in this section, the term an area authority/county vider of mental health, lity, and substance abuse able under Article 2 of this  offer of employment by a er this Chapter to an ion that does not require the occupational license is int to a State and national dicheck of the applicant. If in a resident of this State for then the offer of employment sent to a State and national dicheck of the applicant. The rry record check shall e applicant's fingerprints. If in a resident of this State for en the offer is conditioned criminal history record di. A provider shall not who refuses to consent to a dicheck required by this nerwise provided in this e business days of making if employment, a provider to the Department of 4-19.10 to conduct a dicheck required by this it a request to a private at criminal history record is section. Notwithstanding department of Justice shall ational criminal history ployment positions not	V 133	DEPICIENCY)		

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLE	TED	
		MHL080-166	B. WING		05/22	2/2025	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE			
		125 SHA	MROCK DRIVE				
CABARRI	JS COUNTY GROUP HO	ME 7	IRY, NC 28144				
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON	(X5)	
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	COMPLETE DATE	
V 133	Continued From page	e 8	V 133				
	Department of Health	and Human Services,					
	Criminal Records Che						
	business days of rece	eipt of the national criminal					
	_	the Department of Health					
		, Criminal Records Check					
	Unit, shall notify the p	provider as to whether the					
	information received	may affect the employability					
	of the applicant. In no	case shall the results of the					
		ory record check be shared					
	· · · · · · · · · · · · · · · · · · ·	viders shall make available					
		tion that a criminal history					
		pleted on any staff covered					
	=	inty that has adopted an					
		nance and has access to					
		al Information data bank					
		alf of a provider a State d check required by this					
	_	rovider having to submit a					
		ment of Justice. In such a					
		I commence with the State					
		d check required by this					
	section within five but						
		nployment by the provider.					
		formation received by the					
		al and may not be disclosed,					
	except to the applicar	nt as provided in subsection					
	(c) of this section. Fo	r purposes of this					
	subsection, the term	"private entity" means a					
	business regularly en	gaged in conducting					
	_	d checks utilizing public					
	records obtained fron						
		licant's criminal history					
		one or more convictions of					
		e provider shall consider all					
	_	s in determining whether to					
	hire the applicant:						
		ousness of the crime.					
	(2) The date of the cr						
	(3) The age of the pe	rson at the time of the					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	MHL080-166	B. WING		05/22/2	2025
NAME OF PROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
CABARRUS COUNTY GROUP HOM	E 7	ROCK DRIVE Y, NC 28144			
PREFIX (EACH DEFICIENCY	TEMENT 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 0	(X5) COMPLETE DATE
the person and the job filled.  (6) The prison, jail, pro rehabilitation, and emp person since the date to (7) The subsequent co a relevant offense.  The fact of conviction of shall not be a bar to end listed factors shall be offed for the provider disqualification of the relevant provider may disclosed the criminal history recesto to the disqualification, for the criminal history reapplicant.  (d) Limited Immunity or employee of a provide complies with this secticivil liability for:  (1) The failure of the prindividual on the basis the criminal history recestory record check and criminal offenses if the history record check is compliance with this section in the prindividual on the decimal offenses if the history record check is compliance with this section in the prindividual on the decimal offenses if the history record check is compliance with this section in the prindividual on the decimal offenses if the history record check is compliance with this section in the prindividual on the decimal of the prindivid	surrounding the ne, if known. In the criminal conduct of duties of the position to be obation, parole, ployment records of the the crime was committed. In the crime was c	V 133			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2)				CONSTRUCTION	(X3) DATE SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:			COMPLETED
			A. BOILDING.		
		MUI 000 466	B. WING		05/00/0005
		MHL080-166			05/22/2025
NAME OF P	ROVIDER OR SUPPLIER	STREE	TADDRESS, CITY, STA	TE, ZIP CODE	
CABARRI	JS COUNTY GROUP HO	MF 7 125 SI	HAMROCK DRIVE		
OABARR		SALIS	BURY, NC 28144		
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION SHOULD	()
PREFIX TAG	,	LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF	
				DEFICIENCY)	
V 133	Continued From page	2 10	V 133		
V 100			V 100		
	· ·	nce abuse services. These			
		minal offenses set forth in			
	, ,	rticles of Chapter 14 of the			
		icle 5, Counterfeiting and			
	Issuing Monetary Sub	ve and Legislative Officers;			
		Article 7A, Rape and Other			
		8, Assaults; Article 10,			
		ection; Article 13, Malicious			
	Injury or Damage by				
		Material; Article 14, Burglary			
	_	akings; Article 15, Arson and			
	Other Burnings; Articl	le 16, Larceny; Article 17,			
	Robbery; Article 18, E	Embezzlement; Article 19,			
	False Pretenses and				
		Services by False or			
		edit Device or Other Means;			
		Transaction Card Crime			
		s; Article 21, Forgery; Article			
	26, Offenses Against	, Adult Establishments;			
		n; Article 28, Perjury; Article			
		I, Misconduct in Public			
	•	enses Against the Public			
		Riots and Civil Disorders;			
	Article 39, Protection	of Minors; Article 40,			
	Protection of the Fam	nily; Article 59, Public			
	Intoxication; and Artic	cle 60, Computer-Related			
		also include possession or			
		ion of the North Carolina			
		es Act, Article 5 of Chapter			
		atutes, and alcohol-related			
		e to underage persons in			
	violation of G.S. 18B-	of G.S. 20-138.1 through			
	G.S. 20-138.5.	51 0.0. 20-130. I IIII OUGII			
		ning False Information Any			
		nent who willfully furnishes,			

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supplies, or otherwise gives false information on

STATE FORM 8899 2IDF11 If continuation sheet 11 of 14

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		· ′	CONSTRUCTION		SURVEY PLETED	
			A. BOILDING			
		MHL080-166	B. WING		05	5/22/2025
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
CABARRI	US COUNTY GROUP HO	ME 7	ROCK DRIVE RY, NC 28144			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A	SHOULD BE	(X5) COMPLETE DATE
				DEFICIENCY)		
V 133	criminal history record shall be guilty of a Classian (g) Conditional Employemploy an applicant obtaining the results of check regarding the afollowing requirement (1) The provider shall prior to obtaining the criminal history record subsection (b) of this fingerprint cards as results (2) The provider shall criminal history record business days after the conditional employment 2001-155, s. 1; 2004-	cation that is the basis for a d check under this section ass A1 misdemeanor.  byment A provider may conditionally prior to of a criminal history record applicant if both of the is are met:  not employ an applicant applicant's consent for d check as required in section or the completed equired in G.S. 114-19.10.  submit the request for a d check not later than five the individual begins	V 133			
	failed to request a cri within five days of ma employment affecting #1, #2) and one of on (QP). The findings and Review on 5/15/25 of record revealed: -Hire date was 8/14/0 -Criminal history reco	ew and interviews the facility minal history record check sking a conditional offer of two of two current staff ( e Qualified Professional e: the staff #1's personnel				

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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	
		MHL080-166	B. WING		0:	5/22/2025	
NAME OF P	ROVIDER OR SUPPLIER	STREET	DDRESS, CITY, STATE	, ZIP CODE			
CABARRI	JS COUNTY GROUP HO	ME 7	MROCK DRIVE				
	0.0000000000000000000000000000000000000		JRY, NC 28144	DD0///DED/0 D/ AN 05 0	ODDECTION .		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	TION SHOULD BE COMPLETE THE APPROPRIATE DATE		
V 133	Continued From page 12		V 133				
	-Hire date was 8/4/20.						
	-Criminal history record requested on 8/14/20.						
	Review on 5/15/25 of the QP's personnel record revealed: -Hire date was 4/25/24Criminal history record requested on 4/4/24.						
	Interview on 5/21/25 with the Administrative Staff (AS) #3 revealed: -Shared the responsibility of requesting criminal history record check with AS#4There had been some changes (resignation, retirement) in staff assigned to request the criminal history record checkThere was confusion on when the the criminal history record check should be requestedWas not aware the the criminal history record check should be requested within five days of offer for employment.						
	Interview on 5/21/25 with the AS #4 revealed: -Shared the responsibility of requesting criminal history record check with AS#3There had been some changes (resignation, retirement) in staff assigned to request the criminal history record checkThere was confusion on when the the criminal history record check should be requestedWas not aware the the criminal history record check should be requested within five days of offer for employment.						
	processHad assigned admir	ed: overseeing the hiring nistrative staff (AS#3, AS#4) istory record checks and					

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STATE FORM STATE FORM STATE FORM If continuation sheet 13 of 14

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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							
		MHL080-166	B. WING		05/	22/2025						
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE												
CABARRUS COUNTY GROUP HOME 7  SALISBURY, NC 28144												
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE						
V 133	correctly" -Had reassigned the trecord check to other (requesting criminal habouldn't be a probler-Would ensure crimin	ask of criminal history staff (AS#3, AS#5), "so that istory record check)	V 133									

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