STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ` '		(X3) DATE SURVEY COMPLETED			
AND PLAN OF CORRECTION IDENTIFICATION NO		IDENTIFICATION NOWIGER.	A. BUILDING:		COMP	-EIED	
	MHL0411215		B. WING		07/31/2025		
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
BRANNO	OCK HOME	1612 BRA	NNOCK DRI	VE			
DIVANIA	CKTIONL	GREENSI	BORO, NC 2	7406			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	HOULD BE COMPLETE		
V 000	INITIAL COMMENTS		V 000				
	An annual survey was completed on 7/31/25. Deficiencies were cited.						
	This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with a Developmental Disability.						
	The facility is licensed for 3 and has a current census of 3. The survey sample consisted of audits of 3 current clients.						
V 114	V 114 27G .0207 Emergency Plans and Supplies		V 114				
	10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES (a) Each facility shall develop a written fire plan and a disaster plan and shall make a copy of these plans available to the county emergency services agencies upon request. The plans shall include evacuation procedures and routes. (b) The plans shall be made available to all staff and evacuation procedures and routes shall be posted in the facility. (c) Fire and disaster drills in a 24-hour facility shall be held at least quarterly and shall be repeated for each shift. Drills shall be conducted under conditions that simulate the facility's response to fire emergencies. (d) Each facility shall have a first aid kit accessible for use.						

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

(X6) DATE TITLE

Division of Health Service Regulation		1				
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COMPLETED		
MHL0411215		B. WING		07/31/2025		
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS CITY S	STATE, ZIP CODE		
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BRANNO	OCK HOME		BORO, NC 2			
(V4) ID	SLIMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION)NI	(YE)
(X4) ID PREFIX		MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL	D BE	(X5) COMPLETE
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROI DEFICIENCY)	PRIATE	DATE
				BEI IGIENOT)		
V 114	Continued From pa	ge 1	V 114			
	This Rule is not me	et as evidenced by:				
		view and interview, the facility				
		and disaster drills were held				
	at least quarterly ar	nd repeated for each shift.				
	The findings are:					
	Daview en 7/20/05	and an 7/24/25 of the facility to				
		and on 7/31/25 of the facility's 13/24 - 7/1/25 revealed:				
		Il was held during the second				
	quarter of 2024 (Ap					
	 No first or second shift drill was held during the third quarter of 2024 (July - September) No third shift drill was held during the fourth quarter of 2024 (October - December 2024) 					
	- No first shift drill was held during the first					
	quarter of 2025 (January - March 2025)					
	Review on 7/30/25	and 7/31/25 of the facility's				
		m 5/26/24-7/24/25 revealed:				
		shift drill was held during the				
	second quarter of 2					
		shift drill was held during the				
		4 (July - September)				
		shift drill was held during the 24 (October - December)				
	•	Il during was held the first				
	quarter of 2025 (Ja					
		shift drill was held during the				
	second quarter of 2	2025 (April - June)				
	Intomious 7/00/0	C with ata# #4 wave all all				
		5 with staff #1 revealed: nager was primarily				
		ducting the fire and disaster				
	drills as she only w					
	and the street of the					
	Interview on 7/31/2	5 with the House Manager				
	revealed:	-				
		ifts were as follows: 9 am until				
		om until 12 midnight (second ght until 9 am (third shift)				
	Januara iz iniuliig	griculiui ə arii (umu Simi)				

Division of Health Service Regulation

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY LETED	
		A. BUILDING:					
MHL0411215			B. WING		07/3	07/31/2025	
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
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	GREENSE						
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE COMPLETE		
V 114	Continued From pa	ge 2	V 114				
	- He was the individual who was primarily responsible for conducting the facility's fire and disaster drills						
	Interview on 7/31/25 with the Qualified Professional revealed: - Confirmation that the hours of each shift were as the House Manager reported - Staff were aware of how and when drills were to be held - Would address this issue with staff again to ensure drills were held as required						
V 367	27G .0604 Incident Reporting Requirements		V 367				
	27G .0604 Incident Reporting Requirements 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 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: (1) reporting provider contact and identification information; (2) client identification information; (3) type of incident; (4) description of incident; (5) status of the effort to determine the						

Division of Health Service Regulation

STATE FORM 6899 HKXZ11 If continuation sheet 3 of 7

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(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 1612 BRANNOCK DRIVE GREENSBORO, NC 27406 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLE			MHL0411215	B. WING		07/31/2025	
BRANNOCK HOME 1612 BRANNOCK DRIVE GREENSBORO, NC 27406 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLE	NAME OF I				TATE ZID CODE	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
GREENSBORO, NC 27406 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETED IN COMPLETE	INAIVIE OF I	PROVIDER OR SUPPLIER			,		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLE	BRANNO	OCK HOME					
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE	PRÉFIX	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO	D BE	(X5) COMPLETE DATE
V 367 Continued From page 3 cause of the incident; and (6) other individuals or authorities notified or responding. (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: (1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or (2) the provider obtains information required on the incident form that was previously unavailable. (c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including: (1) hospital records including confidential information; (2) reports by other authorities; and (3) the provider's response to the incident. (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 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 0.300 and 10A NCAC 27E .0104(e)(18). (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	V 367	cause of the incider (6) other indivor responding. (b) Category A and missing or incomple shall submit an updreport recipients by day whenever: (1) the providinformation provide erroneous, mislead (2) the providing required on the inciunavailable. (c) Category A and upon request by the obtained regarding (1) hospital reinformation; (2) reports by (3) the providing (4) Category A and of all level III incide Mental Health, Dev Substance Abuse Subcoming aware of providers shall send incidents involving a Health Service Regulation becoming aware of client death within sor restraint, the provimmediately, as reconstructed.	nt; and viduals or authorities notified B providers shall explain any ete information. The provider lated report to all required the end of the next business ler has reason to believe that d in the report may be ing or otherwise unreliable; or ler obtains information dent form that was previously B providers shall submit, et LME, other information the incident, including: ecords including confidential of other authorities; and ler's response to the incident. B providers shall send a copy intreports to the Division of elopmental Disabilities and services within 72 hours of the incident. Category A did a copy of all level III a client death to the Division of ulation within 72 hours of the incident. In cases of the incident. In cases of seven days of use of seclusion vider shall report the death puired by 10A NCAC 26C AC 27E .0104(e)(18). B providers shall send a he LME responsible for the ere services are provided.	V 367	DETIGIENCY)		

Division of Health Service Regulation STATE FORM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL0411215	B. WING		07/31/2025	
NAME OF PROVIDER OR SUPPLIER STREET ADD			DRESS, CITY, S	STATE, ZIP CODE	•	
BRANNO	OCK HOME		NNOCK DRI			
DIVANING	JOK HOME	GREENSE	BORO, NC 2	7406		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
V 367	Continued From pa	ge 4	V 367			
	(1) medication definition of a level (2) restrictive the definition of a let (3) searches (4) seizures (4) seizures (5) the total number incidents that occur (6) a statement been no reportable incidents have occur meet any of the critical restriction.	number of level II and level III ared; and ent indicating that there have incidents whenever no urred during the quarter that eria as set forth in Paragraphs tule and Subparagraphs (1)				
	This Rule is not met as evidenced by: Based on record review and interview, the facility failed to report level II incidents to the Local Management Entity (LME) responsible for the catchment area where services were provided within 72 hours of becoming aware of the incident affecting 1 of 3 clients (client #3). The findings are: Review on 7/31/25 of client #3's record revealed: An admission date of 3/17/25 Diagnoses of Mild Intellectual Disability; Attention Deficit Hyperactivity Disorder (D/O); Intermittent Explosive D/O and Other Trauma-Stressor Related D/O					

Division of Health Service Regulation

Was in the custody of a Department of Social

Division	<u>of Health Service Re</u>	egulation				
AND DUAN OF CODDECTION IDENTIFICATION AND PER		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
MHL0411215		B. WING		07/31/2025		
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
BRANNOCK HOME		NNOCK DRI BORO, NC 2				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
V 367	Management Entity Review on 7/31/25 Improvement Syste - An level II incid IRIS by the Qualifie 6/18/25 - The level II incid 6/2/25, client #3 left permission at "appr - "Staff (unnam follow him and lost searching for him o - No documentat reflect the name an client #3's DSS soo Manager and when #3's actions on 6/2/ - No documentat reflect the name an law enforcement ac contacted by the un having left the facili during the evening Interview on 7/31/25 - She sent an en worker and his LME of 6/3/25 to notify th the facility during th still had not been lo - An acknowledg	a Care Manager with a Local (LME) of the Incident Response of (IRIS) revealed: ent report last submitted to deprofessional (QP) was on the facility without staff oximately 11:30 pm." ined) called 911 and tried to sight of him and had been ver an hour" ition on the incident report to depend worker, his LME Care they were notified of the client 25 they were notified of the client 25 they were notified of the pency and when they were mamed staff to report client #3 they without staff permission of 6/2/25 with the QP revealed: finall to client #3's DSS social of the care they manager the morning from the client #3 eloped from the evening of 6/2/25 and he cated at the time of the email ement that she had failed to ident report to the LME via	V 367			
		of an email sent to the client				

Manager revealed:

AND DUAN OF CODDECTION DENTIFICATION NUMBER.		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
MHL0411215		B. WING		07/3	07/31/2025	
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
BRANNO	OCK HOME		NNOCK DR BORO, NC 2			
(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 SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
V 367	DSS social worker	6/3/25, the QP notified the and the LME Care Manager of ped from the facility on 6/2/25	V 367	DEFICIENCY)		

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Division of Health Service Regulation STATE FORM