

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL032-646	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/17/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER L'ARCHE NORTH CAROLINA JEROME HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 919 JEROME ROAD DURHAM, NC 27713
--	--

(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 000	<p>INITIAL COMMENTS</p> <p>An annual survey was completed on October 17, 2025. Deficiencies were cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .5600F Supervised Living for Alternative Family Living.</p> <p>This facility is licensed for 3 and has a current census of 4. The survey sample consisted of audits of 3 current clients.</p>	V 000		
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> <p>(1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement;</p> <p>(2) strategies;</p> <p>(3) staff responsible;</p> <p>(4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both;</p> <p>(5) basis for evaluation or assessment of outcome achievement; and</p> <p>(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.</p>	V 112		

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL032-646	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/17/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER L'ARCHE NORTH CAROLINA JEROME HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 919 JEROME ROAD DURHAM, NC 27713
--	--

(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 112	<p>Continued From page 1</p> <p>This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to obtain a written consent by a responsible party for a client's treatment plan affecting two of three audited clients (#1 and #2). The findings are:</p> <p>Review on 10/16/25 of client #1's record revealed: -Date of admission was 2/5/25. -Diagnoses was Generalized Anxiety Disorder, Autistic Disorder and Moderate Intellectual Disability. -Individualized Support Plan (ISP) had no written consent or agreement by client #1's responsible party.</p> <p>Review on 10/16/25 of client #2's record revealed: -Date of admission was 1/13/25. -Diagnoses was Autistic Disorder, Cerebral Palsy, Attention Deficit Hyperactivity Disorder and Generalized Anxiety Disorder. -ISP had no written consent or agreement by client #2's responsible party.</p> <p>Interview on 10/17/25 with the Qualified Professional (QP) revealed: -The clients' plans were generated by the Care Managers through the Local Management Entity/Managed Care Organization. -"Those plans possibly had signatures, however</p>	V 112		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL032-646	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/17/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER L'ARCHE NORTH CAROLINA JEROME HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 919 JEROME ROAD DURHAM, NC 27713
--	--

(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 112	Continued From page 2 we just don't have the copy with the signature." -She confirmed the facility failed to have written consent or agreement by the client or responsible party for clients #1 and #2. Interview on 10/16/25 with the Operations Manager confirmed: -The facility failed to have written consent or agreement by the client or responsible party for clients #1 and #2.	V 112		
V 113	27G .0206 Client Records 10A NCAC 27G .0206 CLIENT RECORDS (a) A client record shall be maintained for each individual admitted to the facility, which shall contain, but need not be limited to: (1) an identification face sheet which includes: (A) name (last, first, middle, maiden); (B) client record number; (C) date of birth; (D) race, gender and marital status; (E) admission date; (F) discharge date; (2) documentation of mental illness, developmental disabilities or substance abuse diagnosis coded according to DSM IV; (3) documentation of the screening and assessment; (4) treatment/habilitation or service plan; (5) emergency information for each client which shall include the name, address and telephone number of the person to be contacted in case of sudden illness or accident and the name, address and telephone number of the client's preferred physician; (6) a signed statement from the client or legally responsible person granting permission to seek emergency care from a hospital or physician;	V 113		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL032-646	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/17/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER L'ARCHE NORTH CAROLINA JEROME HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 919 JEROME ROAD DURHAM, NC 27713
--	--

(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 113	<p>Continued From page 3</p> <p>(7) documentation of services provided; (8) documentation of progress toward outcomes; (9) if applicable: (A) documentation of physical disorders diagnosis according to International Classification of Diseases (ICD-9-CM); (B) medication orders; (C) orders and copies of lab tests; and (D) documentation of medication and administration errors and adverse drug reactions. (b) Each facility shall ensure that information relative to AIDS or related conditions is disclosed only in accordance with the communicable disease laws as specified in G.S. 130A-143.</p> <p>This Rule is not met as evidenced by: Based on record reviews and interview, the facility failed to maintain required documentation in the client records affecting three of three audited current clients (#1, #2 and #3). The findings are:</p> <p>Review on 10/16/25 of client #1's record revealed: -Date of admission was 2/5/25. -Diagnoses was Generalized Anxiety Disorder, Autistic Disorder and Moderate Intellectual Disability. -No signed statement from the client or legally responsible person granting permission to seek emergency care from a hospital or physician.</p> <p>Review on 10/16/25 of client #2's record revealed:</p>	V 113		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL032-646	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/17/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER L'ARCHE NORTH CAROLINA JEROME HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 919 JEROME ROAD DURHAM, NC 27713
--	--

(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 113	<p>Continued From page 4</p> <ul style="list-style-type: none"> -Date of admission was 1/13/25. -Diagnoses was Autistic Disorder, Cerebral Palsy, Attention Deficit Hyperactivity Disorder and Generalized Anxiety Disorder. -No signed statement from the client or legally responsible person granting permission to seek emergency care from a hospital or physician. <p>Review on 10/16/25 of client #3's record revealed:</p> <ul style="list-style-type: none"> -Date of admission was 3/15/25. -Diagnoses was Autism and Asthma. -No signed statement from the client or legally responsible person granting permission to seek emergency care from a hospital or physician. <p>Interview on 10/17/25 with the Qualified Professional (QP) revealed:</p> <ul style="list-style-type: none"> -She was responsible for the client records. -"I'm not clear about everything that is needed for the client records." -"Some of the documentation was not in place prior to my tenure." -She confirmed the facility failed to maintain completed records for clients #1, #2 and #3. <p>Interview on 10/16/25 with the Operations Manager revealed:</p> <ul style="list-style-type: none"> -The QP was responsible for the client record documentation. -She confirmed the facility failed to maintain completed records for clients #1, #2 and #3. 	V 113		
V 131	<p>G.S. 131E-256 (D2) HCPR - Prior Employment Verification</p> <p>G.S. §131E-256 HEALTH CARE PERSONNEL REGISTRY (d2) Before hiring health care personnel into a</p>	V 131		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL032-646	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/17/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER L'ARCHE NORTH CAROLINA JEROME HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 919 JEROME ROAD DURHAM, NC 27713
--	--

(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 131	<p>Continued From page 5</p> <p>health care facility or service, every employer at a health care facility shall access the Health Care Personnel Registry and shall note each incident of access in the appropriate business files.</p> <p>This Rule is not met as evidenced by: Based on record reviews and interview, the facility failed to ensure the Health Care Personnel Registry (HCPR) was accessed prior to employment affecting three of three audited staff (Qualified Professional (QP), #1 and #2). The findings are:</p> <p>Review on 10/16/25 of the facility's personnel records revealed:</p> <p>QP- -Date of hire was 5/27/25. -No documentation the HCPR was accessed prior to hire.</p> <p>Staff #1- -Date of hire was 1/6/25. -Hired as a Direct Support Professional (DSP). -No documentation the HCPR was accessed prior to hire.</p> <p>Staff #2- -Date of hire was 1/27/25. -Hired as a DSP. -No documentation the HCPR was accessed prior to hire.</p> <p>Interview on 10/16/25 with the Operations</p>	V 131		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL032-646	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/17/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER L'ARCHE NORTH CAROLINA JEROME HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 919 JEROME ROAD DURHAM, NC 27713
--	--

(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 131	Continued From page 6 Manager revealed: -She was responsible for the personnel records. -"I forgot to access the HCPR for those staff." -"I was also confused with the HCPR check and criminal background check." -She confirmed the facility failed to ensure the HCPR was accessed for the QP, staff #1 and staff #2 prior to employment.	V 131		