

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL008-006	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/21/2026
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NAME OF PROVIDER OR SUPPLIER FARMWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 220 WARD ROAD WINDSOR, NC 27983
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(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>A complaint survey was completed on April 21, 2026 . The complaints were unsubstantiated (Intakes #NC00236722 & #NC00236723). A deficiency was cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disability.</p> <p>This facility is licensed for 4 and has a current census of 4. The survey sample consisted of audits of 1 current client.</p>	V 000		
V 318	<p>130 .0102 HCPR - 24 Hour Reporting</p> <p>10A NCAC 130 .0102 INVESTIGATING AND REPORTING HEALTH CARE PERSONNEL The reporting by health care facilities to the Department of all allegations against health care personnel as defined in G.S. 131E-256 (a)(1), including injuries of unknown source, shall be done within 24 hours of the health care facility becoming aware of the allegation. The results of the health care facility's investigation shall be submitted to the Department in accordance with G.S. 131E-256(g).</p> <p>This Rule is not met as evidenced by: Based on record review and interview, the facility failed to report allegations of abuse to the Health Care Personnel Registry (HCPR) for 1 of 1</p>	V 318		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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V 318	<p>Continued From page 1</p> <p>former paraprofessional staff (FS #7) within 24 hours. The findings are:</p> <p>Review on 4/20/26 of FS #7's personnel file revealed:</p> <ul style="list-style-type: none"> - Hired 6/12/17 and terminated 3/31/26 <p>Review on 4/20/26 of the facility's records revealed:</p> <ul style="list-style-type: none"> - A medical consultation form dated 3/17/26 written and signed by client #1's Nurse Practitioner: "Patient (client #1) is concern with left arm pain. When moving arm patient appears to be in pain...Patient also states with his hand, he made a fist and punched and acted as if someone pushed/punched him." - A medical consultation form dated 3/17/26 written and signed by staff #1: "Consumer (client #1) seen for follow-up [Local Medical Center]. Consumer was complaining about left arm pain hurting where staff notice scratches on hand...doctor got consumer to act out what happened...She (doctor) told staff (staff #1) to take consumer to get x-rays on left arm at hospital. Staff also informed manager (Residential Manager) as well." - An Internal Investigation Findings Report dated 3/19/26 typed and signed by Human Resources (HR)/Qualified Professional (QP): "...On March 19, 2026, the provider became aware of an anonymous allegation asserting that staff member, [FS #7], punched consumer, [client #1], in the side while the consumer was under his care at the residential facility..." - An Incident Response Improvement System (IRIS) report submitted 3/22/26 contained the following information: <ul style="list-style-type: none"> - "Allegation of Abuse, Neglect or Exploitation...On March 19, 2026 [Local County] Department of Social Services (DSS) came on 	V 318		

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V 318	<p>Continued From page 2</p> <p>site (facility) and informed the provider that an allegation was made against a staff member working in the member's residential facility. The allegation was staff member ([FS#7]) punched the member in his side..."</p> <p>Interviews on 4/20/26 and 4/21/26 the HR/QP reported:</p> <ul style="list-style-type: none"> - Was responsible to reporting allegations to the HCPR - FS #7 was reported to the HCPR on 3/22/26 when she submitted the IRIS report - She was on vacation when DSS notified the facility of client #1's allegation on 3/19/26 - The QP/Administrator began the initial investigation on 3/19/26 - Wasn't aware the facility was notified of client #1's allegation on 3/17/26 - Knew to report allegations to the HCPR "immediately," but she didn't notify HCPR immediately because she notified them through the IRIS report - "I'm the only one" that completes IRIS reports <p>Interviews on 4/20/26 and 4/21/26 the QP/Administrator reported:</p> <ul style="list-style-type: none"> - Was notified of client #1's allegation against FS #7 when DSS arrived to the facility on 3/19/26 - Immediately conducted an investigation - The HR/QP was responsible for notifying the HCPR of allegations - Believes the HR/QP was on vacation when the facility was notified of client #1's allegation - She was responsible for notifying the HCPR when the HR/QP wasn't available - Was unaware of client #1's allegation made on 3/17/26 	V 318		