| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | | | |
|--------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------|----------------------------|---------------------------------------------------------------------------|-------------------------------|------------------|--|--|
| AND PLAN (| OF CORRECTION | IDENTIFICATION NUMBER. | A. BUILDING: | | COMPL | EIED | | |
| | | MHL060-160 | B. WING | | 03/27/2018 | | | |
| NAME OF P | ROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, STA | TE, ZIP CODE | | | | |
| | 232 STILLWELL OAKS CIRCLE | | | | | | | |
| INREACH | STILLWELL OAKS | CHARLO | TTE, NC 28212 | | | | | |
| (X4) ID | SUMMARY ST | ATEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF CORRE | CTION | (X5) | | |
| PREFIX TAG | , | Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | PREFIX TAG | (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY) | | COMPLETE DATE | | |
| V 000 | INITIAL COMMENTS | | V 000 | | | | | |
| | An annual survey was deficiency was cited. | s completed on 3/27/18. A | | | | | | |
| | This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities. | | | | | | | |
| | · · | · | | | | | | |
| V 291 | V 291 27G .5603 Supervised Living - Operations | | V 291 | | | | | |
| | 10A NCAC 27G .560 | 3 OPERATIONS | | | | | | |
| | | ty shall serve no more than | | | | | | |
| | six clients when the c | lients have mental illness or | | | | | | |
| | T | lities. Any facility licensed | | | | | | |
| | | d providing services to more | | | | | | |
| | | t time, may continue to | | | | | | |
| | | o more than the facility's | | | | | | |
| | licensed capacity. | tion. Coordination shall be | | | | | | |
| | | the facility operator and the | | | | | | |
| | | s who are responsible for | | | | | | |
| | | | | | | | | |
| | treatment/habilitation or case management. (c) Participation of the Family or Legally | | | | | | | |
| | Responsible Person. Each client shall be | | | | | | | |
| | provided the opportur | nity to maintain an ongoing | | | | | | |
| | relationship with her | or his family through such | | | | | | |
| | means as visits to the | e facility and visits outside | | | | | | |
| | | shall be submitted at least | | | | | | |
| | | t of a minor resident, or the | | | | | | |
| | • • • | erson of an adult resident. | | | | | | |
| | conference and shall | iting or take the form of a | | | | | | |
| | progress toward mee | | | | | | | |
| | | s. Each client shall have | | | | | | |
| | | based on her/his choices, | | | | | | |
| | needs and the treatm | | | | | | | |
| | | signed to foster community | | | | | | |
| | | ay be limited when the court | | | | | | |
| | | olved or when health or | | | | | | |
| | safety issues become | e a primary concern. | | | | | | |

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

(X6) DATE TITLE

| , | | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE | CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | |
|----------------------------------------------|---------------------------------------------------|------------------------------------------------------------|-------------------|--------------------------------------------------------|-------------------|-------------------------------|--|
| AND PLAN OF CORRECTION IDENTIFICATION NUMBER | | IDENTIFICATION NUMBER: | A. BUILDING: | | COMP | LETED | |
| | | | | | | | |
| MHL060-160 | | B. WING | | 03/ | 27/2018 | | |
| NAME OF P | ROVIDER OR SUPPLIER | STREET A | ODRESS, CITY, STA | TE, ZIP CODE | | | |
| INDEACH | OTH LMELL CAKE | 232 STIL | LWELL OAKS C | IRCLE | | | |
| INREACH | STILLWELL OAKS | CHARLO | TTE, NC 28212 | | | | |
| (X4) ID | | ATEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN C | | (X5) | |
| PREFIX TAG | ` | Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | PREFIX TAG | (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN | O THE APPROPRIATE | COMPLETE DATE | |
| V 291 | Continued From page | e 1 | V 291 | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | This Rule is not met | as evidenced by: | | | | | |
| | | ews and interviews, the | | | | | |
| | facility failed to ensur | | | | | | |
| | | 1 of 3 clients (#2). The | | | | | |
| | findings are: | 1 61 6 616116 (112). 1116 | | | | | |
| | midnigo di o. | | | | | | |
| | Review on 3/21/18 of client #2's record revealed: | | | | | | |
| | -admission date of 7/13/79 with diagnoses of | | | | | | |
| | | nental Disabilities-Moderate | | | | | |
| | and Cerebral Palsy; | | | | | | |
| | | nt falls due to weakness on | | | | | |
| | left side, unsteady gait; | | | | | | |
| | -treatment plans date | ed 12/1/17 and 2/1/18 | | | | | |
| | documented the follo | wing goals: ensure | | | | | |
| | | anger danger, prepare | | | | | |
| | _ | , use cane when walking | | | | | |
| | | ensure eats balanced meals | | | | | |
| | instead of snacking; | | | | | | |
| | | verbal prompts, education, | | | | | |
| | reminders, praise, encouragement, teach, | | | | | | |
| | explain; | | | | | | |
| | I | t falls included using a | | | | | |
| | manuel wheelchair in | , , | | | | | |
| | | ed areas, prompts and | | | | | |
| | | se cane properly, hand rails bench in shower, wedge in | | | | | |
| | | , inflatable cushion for falls, | | | | | |
| | | aces and steps, teach | | | | | |
| | | assistance and cane to | | | | | |
| | | she report any falls, keep | | | | | |
| | | er when she uses her cane; | | | | | |
| | | 12/2017 documented 10 | | | | | |
| | | 018-3/2018 documented 9 | | | | | |
| | falls showing increas | | | | | | |
| | -no documentation of | | | | | | |
| | assessments/evaluat | | | | | | |
| increase in falls. | | | | | | | |

Division of Health Service Regulation

STATE FORM 6899 RN8W11 If continuation sheet 2 of 5

| DIVISION | of Health Service Regu | lation | | | | | |
|-------------------------------------------------------|----------------------------------------------|------------------------------|------------------|---------------------------------|------------|--|--|
| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION | | (X3) DATE SURVEY | | | |
| AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | A. BUILDING: | | COMPLETED | | | |
| | | | | | | | |
| MIII 000 400 | | B. WING | | 02/07/0040 | | | |
| | | MHL060-160 | | | 03/27/2018 | | |
| NAME OF P | ROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, STA | TE, ZIP CODE | | | |
| | | 232 STILI | WELL OAKS CI | RCLE | | | |
| INREACH | STILLWELL OAKS | CHARLO | TTE, NC 28212 | | | | |
| (V4) ID | SLIMMARY ST | ATEMENT OF DEFICIENCIES | ID. | PROVIDER'S PLAN OF CORRECTION | V (VE) | | |
| (X4) ID PREFIX | | Y MUST BE PRECEDED BY FULL | ID PREFIX | (EACH CORRECTIVE ACTION SHOULD | (-, | | |
| TAG | REGULATORY OR I | SC IDENTIFYING INFORMATION) | TAG | CROSS-REFERENCED TO THE APPROPR | RIATE DATE | | |
| | DEFICIENCY) | | | | | | |
| V 291 | Continued From page | . 2 | V 291 | | | | |
| V 201 | Continued From page | , 2 | 1251 | | | | |
| | | | | | | | |
| | Interview on 3/21/18 | with client #2 revealed: | | | | | |
| | -"now and then fall do | own;" | | | | | |
| | -never gotten hurt; | | | | | | |
| | -sometimes loses her | balance; | | | | | |
| | -always uses her can | | | | | | |
| | -usually falls on her b | | | | | | |
| | -gets up herself most | | | | | | |
| | -staff tell her to walk s | - | | | | | |
| | -wear shoes around h | | | | | | |
| | -staff holds her when | she walks on steps or | | | | | |
| | outside; | | | | | | |
| | -staff helps her in the | shower. | | | | | |
| | Interview on 3/21/18 with staff #1 revealed: | | | | | | |
| | -try to prevent client # | | | | | | |
| | | f help her when doing tasks; | | | | | |
| | -hold onto her arm in | - · | | | | | |
| | -she tries to carry her | laundry basket, prompt her | | | | | |
| | not to; | | | | | | |
| | -assist her with showers; | | | | | | |
| -prompt her to use her | | | | | | | |
| | -client #2 just loses he | er balance at times. | | | | | |
| | Interview on 3/21/18 | with staff #2 revealed: | | | | | |
| | -client #2 falls, try to s | | | | | | |
| | | ne, monitor and assist in | | | | | |
| | showers, | , | | | | | |
| | -reminders not to carr | ry things; | | | | | |
| | -when go places, hold | | | | | | |
| | -loses balance, doesr | | | | | | |
| | -works mostly with cli | | | | | | |
| | Interview on 3/22/18 | with former staff #4 | | | | | |
| | revealed: | with former stall #4 | | | | | |
| | -worked on weekends | s with client #2: | | | | | |
| | -to prevent falls, remi | • | | | | | |
| | - | ver, use wheelchair in | | | | | |
| | וווטווונטו/מטטוטו מו טווטו | voi, use wilectollall III | 1 | | | | |

Division of Health Service Regulation

community for long distances and crowded places, assist getting in and out of van;

STATE FORM 6899 RN8W11 If continuation sheet 3 of 5

| Division of Health Service Regulation | | | | | | | |
|---------------------------------------|---------------------------------------------------------------------------|-----------------------------------------|----------------------------|---------------------------------------------|------------------|--|--|
| STATEMENT OF DEFICIENCIES (X1) P | | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE CONSTRUCTION | | (X3) DATE SURVEY | | |
| AND PLAN OF CORRECTION | | IDENTIFICATION NUMBER: | A. BUILDING: | | COMPLETED | | |
| | | | | | | | |
| | | MHL060-160 | B. WING | | 03/27/2018 | | |
| NAME OF PI | ROVIDER OR SUPPLIER | STREET A | DDRESS, CITY, STA | TE, ZIP CODE | | | |
| | | 232 STIL | LWELL OAKS C | IRCLE | | | |
| INREACH | STILLWELL OAKS | CHARLO | OTTE, NC 28212 | | | | |
| (X4) ID | SUMMARY STA | ATEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF CORRECTION | (X5) | | |
| PREFIX | | Y MUST BE PRECEDED BY FULL | PREFIX | (EACH CORRECTIVE ACTION SHOULD | | | |
| TAG | REGULATORY OR I | SC IDENTIFYING INFORMATION) | TAG | CROSS-REFERENCED TO THE APPROPE DEFICIENCY) | TATE DATE | | |
| V 291 | Continued From 1999 | . 0 | V 291 | | | | |
| V 291 | Continued From page | 3 | V 291 | | | | |
| | -think falls have incre | • | | | | | |
| | -just standing there ar | | | | | | |
| | | right beside client #2 and | | | | | |
| | she fell with no warning | ng, client #2 was just | | | | | |
| | standing still; | P | | | | | |
| | -falls when she is star | | | | | | |
| | | 2's falls at all staff meetings | | | | | |
| | and ways to prevent f | alls. | | | | | |
| | Interview on 3/21/18 v | with the Group Home | | | | | |
| | Manager revealed: | · | | | | | |
| | -client #2 has falls; | | | | | | |
| | -falls are unexpected; | | | | | | |
| | -walks with cane, pro | | | | | | |
| | | surfaces like curbs, help | | | | | |
| | her in and out of van, | | | | | | |
| | community and crowd | | | | | | |
| | | evenings Mondays through | | | | | |
| | Thursdays from 3:30- | 7:30pm; | | | | | |
| | -keep journal of falls;-been recently to her | neurologist: | | | | | |
| | -client #2 always falle | | | | | | |
| | -not sure about any re | _ · | | | | | |
| | evaluations/assessme | | | | | | |
| | | | | | | | |
| | Interview on 3/22/18 v | with client #2's legal | | | | | |
| | guardian revealed: | | | | | | |
| | | n like this "all her life;" | | | | | |
| | -more falls recently;-falling backward instead | ead of forward now: | | | | | |
| | | fall, has extra staff coming | | | | | |
| | in to help client #2; | iaii, iias extia stali collillig | | | | | |
| | • | ist recently, he checked her | | | | | |
| | out and said she was | - · · · · · · · · · · · · · · · · · · · | | | | | |
| | | Neurologist for increased | | | | | |

falls;

fell backward;

-was at home, standing by dishwasher and just

-not aware of any recent gait evaluations or physical therapy/occupational therapy

STATE FORM 6899 RN8W11 If continuation sheet 4 of 5

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | | (X3) DATE SURVEY COMPLETED | | |
|-----------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|---------------------|----------------------------------------------------------------------------------|----------------------------------|--------------------------|--|
| | | MHL060-160 | B. WING | | 03 | 8/27/2018 | |
| NAME OF P | ROVIDER OR SUPPLIER | STREET A | ADDRESS, CITY, STAT | E, ZIP CODE | | | |
| INREACH | STILLWELL OAKS | 232 STII | LWELL OAKS CIF | RCLE | | | |
| INICAOTI | INREACH/STILLWELL OAKS CHARLOTTE, NC 28212 | | | | | | |
| (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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC | ION SHOULD BE THE APPROPRIATE | (X5) COMPLETE DATE | |
| V 291 | 291 Continued From page 4 | | V 291 | | | | |
| | assessments. | | | | | | |
| | evaluation was compl -no recent gait assess -plan to address level regards to falls; -also will address no | d: /occupational therapy leted in 2011; sments/evaluations; I of residential supports in | | | | | |
| | | | | | | | |

Division of Health Service Regulation

STATE FORM 6899 RN8W11 If continuation sheet 5 of 5