Division of Health Service Regulation

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED  R 10/03/2019	
mhl096-192		B. WING				
NAME OF I	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	1070	.0.2010
ASA LIV	ING I	1308 BEN	N BREWINGT	ON DRIVE		
AOA LIVI		GOLDSB	ORO, NC 27	530		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
V 000	INITIAL COMMENT	-S	V 000			
	An annual survey w Deficiencies were c	ras attempted on 10/3/19. ited.				
	Due to the presence survey was not com	e of live bed bugs, the annual apleted.				
	This facility is licensed for the following service category: 10A NCAC 27G .5600A Supervised Living for Adults with Mental Illness.					
V 736	27G .0303(c) Facili	ty and Grounds Maintenance	V 736			
	10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS (c) Each facility and its grounds shall be maintained in a safe, clean, attractive and orderly manner and shall be kept free from offensive odor.					
		ons and interviews the facility in a safe, clean, attractive				
	1:30pm revealed:	n/2/19 at approximately				
	drawer full of clothe stains in a spatter p #2's bed.	es on the floor. Dark brown pattern on the wall beside client				
	Director opened clic spilled out into the b worn, exposing bar	m: When the Group Home ent #1's closet doors, clothing bedroom. Finish on headboard e wood surface underneath.				
		m: 4 drawer chest with the awer off track and unable to				

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

(X6) DATE TITLE

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X A. BUILDING:		(X3) DATE SURVEY COMPLETED	
					R	
mhl096-192		B. WING		10/0	3/2019	
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
ASA LIVI	NG I		BREWINGT			
(V4) ID	QUIMMADV QTA	TEMENT OF DEFICIENCIES	DRO, NC 27	PROVIDER'S PLAN OF CORRECTION	)N	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
V 736	Continued From pa	ge 1	V 736			
	close securely.					
	Interview on 10/2/19 had been broken al	9 client #2 stated his drawer pout 10 months.				
	Interview on 10/2/19 Group Home Director stated: -Client #1 was a hoarder. That was the reason the clothing was stacked inside his closet.  This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.					
V 738	27G .0303(d) Pest	Control	V 738			
	10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS (d) Buildings shall be kept free from insects and rodents.					
	was not kept free fr Observations on 10 PM revealed: -Round to oval redoclient #2's comforte -Approximately 23 It wall beside client #2 -Numerous small be #2's mattressApproximately 5 ve on client #2's box s	on and interview, the facility om insects. The findings are: 0/2/19 at approximately 1:40 dish brown dead bed bugs on or. Drown stained areas on left 2's bed near the window. The rown stained areas on client bery small live bedbugs crawling				

6899

Division of Health Service Regulation STATE FORM

121511 If continuation sheet 2 of 7

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				OATE SURVEY OMPLETED	
					R		
mhl096-192		B. WING	·	10/0	3/2019		
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE			
ASA LIVI	NG I		BREWINGT				
			ORO, NC 27				
(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 APPROINT DEFICIENCY)	D BE	(X5) COMPLETE DATE	
V 738	Continued From pa	ge 2	V 738				
	-Approximately 3 round to oval reddish brown live bedbugs crawling on client #2's mattressApproximately 3 dead bed bugs on client #4's mattress that was encased in the manufacturer's plastic.  Interview on 10/2/19 client #2 stated: -Bedbugs were present and came out at nightHe had a plastic covering over his mattresses but the Director took it offThe bedbugs were present in his room for at least one year and a halfThe bedbugs cling to his clothesThe bedbugs crawl on the wall and dieHe saw them on the bathroom floorNo pest control company had been to the facility since February 2019 and only sprayed the floor during the visit.  Interview on 10/2/19 the Group Home Director stated: -The facility had a bedbug infestation about a year and a half agoThe facility had a tent treatment for bedbugs back in the pastThe facility currently had no bed bugs.						
	Control Agency Sta -The facility's first b 9/6/17, at which tim treatment instead o treatment." The fac "basic," was on 12/2 found during a mair 12/18/17After 12/22/17, the reinspection or qua	ed bug treatment was done e they received only a "basic" f the initially planned "tent" ility's last treatment, another 22/17, after bed bugs were ntenance inspection done facility never scheduled a rterly bed bug services as the pest control company					

Division of Health Service Regulation

STATE FORM 6899 121511 If continuation sheet 3 of 7

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
7			A. BUILDING:		R	
mhl096-192		B. WING			3/2019	
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
ASA LIV	ING I		BREWINGT			
	- -	GOLDSBO	DRO, NC 27	530		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
V 738	Continued From pa	ge 3	V 738			
	-There was a service but it had been can documented why the service control company are for bed bug treatmed done, but canceled service could be seconcellation was the company."	ce date scheduled for 3/14/18 celed. No reason was his was canceled. facility contacted the pest had requested another contract ent. A "service ticket" was by the facility before the heduled. The reason given for the facility had found a "cheaper"				
	Director stated: -He thought the firs was a "tent treatment the closets and take Everyone had to lear eturn for at least 1 After 12 hours we had to leave the clothes to the launce technicians brough. The pest control of the 2nd treatment and the frame process to reclothing through the These treatments was not exactly surstreatment because good." He thought they would be "ok." sprays were not for When asked where following the last treatment and the say about 10 days at they had bed bugs, bathroom that look checking the client.	occurred over a year ago. He e of the date. nspections after the 2nd he was told "you should be with regular sprays monthly He knew these regular				

Division of Health Service Regulation

STATE FORM 6899 121511 If continuation sheet 4 of 7

Division of Health Service Regulation								
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY				
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED		
				_	_			
			D WING		R			
		mhl096-192	B. WING		10/03/2019			
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DDESS CITY O	STATE, ZIP CODE				
NAIVIE OF	-ROVIDER OR SUFFLIER			,				
ASA LIV	NG I	1308 BEN	BREWINGT	ON DRIVE				
, (0) ( =. )		GOLDSB	ORO, NC 27	530				
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON	(X5)		
PREFIX		MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL		COMPLETE		
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO	PRIATE	DATE		
				DEFICIENCY)				
\/ 738	Continued From pa	ge 1	V 738					
V 730	Continued From pa	ge 4	V 730					
	checking mattresse	es every other day. He had not						
		ne mattresses until they were						
		ors on 10/2/19. This was the						
	,	en anything in a while.						
		he pest control company had						
		March 2019 for bed bug						
		he had seen a bug in the						
		ntacting the pest control						
		to the hardware store and						
	talked with a "technician" who showed him some spray that could be mixed with water. Rather							
		st control services, he used						
	this spray and foun	d it to be "very effective"						
	because he did not see any more suspicious bugs. When asked if he had sprayed after seeing the bug about 10 days ago, stated he had not.							
		ttresses had been purchased						
		ought mattresses for client #2						
		less than 6 months ago. He						
		astic covering but did not put						
		ound their mattresses. He did						
		after seeing the "bugs" in the						
		2019 or 10 days prior when						
		bathroom. When he						
	•	resses for the other clients he						
	decided it was a go	od idea to leave the plastic in						
	place.							
	<ul> <li>He would make su</li> </ul>	re reinspection's would follow						
	future treatments to	determine if the bed bugs						
	had been effectively	y exterminated						
	Review on 10/2/19	of a Plan of Protection signed						
	by the Group Home Director dated 10/2/19							
	revealed:							
		action will the facility take to						
		f the consumer in your care?:						
		oray or wipe beds down with						
		linens in the electric dryer at						
		vel possible. I will place bed						
encasements on all beds that are not already								

6899

Division of Health Service Regulation STATE FORM

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND FEAR OF CONNECTION		BENTI TOATION NOMBER.	A. BUILDING:	<del></del>		
mhl096-192		B. WING		R 10/03/2019		
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ASA LIV	ING I	1308 BEN	BREWINGT	ON DRIVE		
ASA LIV		GOLDSB	ORO, NC 27	530		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
V 738	Continued From pa	ge 5	V 738			
	control company. The technician out tomo treatment is needed done as soon as the soon as t	en in touch with local pest They will be sending a prow to see what level of d. We will have a treatment ey can schedule the facility." The second of the se				
	bedding that needs On 10/2/19 bed bug	them." gs, alive and dead, were seen				
	in 3 of 3 client bedrooms during the facility tour. The facility had a history in 2017 of treatment for bed bugs without a final inspection to determine the infestation had been eradicated. In March 2019 the Division of Health Service Regulation Construction Section cited the facility for bed bugs. In March of 2019 the facility contacted a professional pest control service for bed bug services after seeing "suspicious" bugs. However, the facility chose to use a "cheaper"					
	store and did not ap the clients' beds. The stated he had seen facility approximate	a spray from a local hardware oply mattress encasements to the Group Home Director more "suspicious bugs" in the ly 10 days prior to the survey, and a past central contributes to				
	inspect. The facility the bed bug infesta resulted in placing the environment, detring and welfare. This derule violation. If the within 45 days, and	ed a pest control service to 's failure to professionally treat tion from 2017 to current has the clients in an unsafe nental to their health, safety eficiency constitutes a Type B violation is not corrected administrative penalty of				
\$200.00 per day will be imposed for each day the facility is out of compliance beyond the 45th day.						

Division of Health Service Regulation

STATE FORM 6899 121511 If continuation sheet 6 of 7

PRINTED: 10/22/2019 FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_\_\_\_\_ R B. WING \_ mhl096-192 10/03/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1308 BEN BREWINGTON DRIVE **ASA LIVING I** GOLDSBORO, NC 27530 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE (X5) COMPLETE DATE (X4) ID PRÉFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY)

Division of Health Service Regulation