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: B. WING MHL034-288 01/24/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2415 OLD SALISBURY ROAD INDEPENDENT LIVING GROUP HOME AT OLD SALISE WINSTON-SALEM, NC 27127 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE **PREFIX** (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) V 000 INITIAL COMMENTS V 000 **DHSR** - Mental Health An annual and complaint survey was completed on 1/24/2020. The complaint was unsubstantiated (Intake # NC160182). Deficiencies were cited. FEB 13 2020 This facility is licensed for the following service Lic. & Cert. Section category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disability. V 120 27G .0209 (E) Medication Requirements V 120 10A NCAC 27G .0209 MEDICATION REQUIREMENTS The agency wull ensure that all (e) Medication Storage: (1) All medication shall be stored: (A) in a securely locked cabinet in a clean. medications in a well-lighted, ventilated room between 59 degrees and 86 degrees Fahrenheit; secure manner. The (B) in a refrigerator, if required, between 36 degrees and 46 degrees Fahrenheit. If the Staff will unsure refrigerator is used for food items, medications shall be kept in a separate, locked compartment that unless the or container; (C) separately for each client; clunt has an order (D) separately for external and internal use: (E) in a secure manner if approved by a physician to self adminster for a client to self-medicate. (2) Each facility that maintains stocks of hat medication controlled substances shall be currently registered under the North Carolina Controlled out be locked in Substances Act, G.S. 90, Article 5, including any subsequent amendments. a Secure manner. of and the agency This Rule is not met as evidenced by: Based on observation, record reviews and interviews, the facility failed to store medications securely affecting 1 of 3 clients (#3). The findings are: Division of Health Service Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPL R REPRESENTATIVE'S SIGNATURE

(X6) DATE!

Division of Health Service Regulation			- CONCTRUCTION	(X3) DATE S	(X3) DATE SURVEY			
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	Service and American American Services and A			in u ho	ONDE	$\nu$ $\alpha$		
70.	Daview on 1/15/2020	0 of client #3's record		pu De				١
	revealed:	o of cheff #03 federa						
	- Admission date: 9/	18/2018						1
		Depressive Disorder (D/O),						1
	recurrent with psych	otic features; Attention						1
	Deficit-Hyperactivity	D/O; Intermittent Explosive						
	D/O: Oppositional D	efiant D/O; Post Traumatic						1
	Stress D/O: Mild Inte	ellectual Disabilities; Allergic						1
	Rhinitis; Asthma; Ec	zema; Morbid Obesity;						
	Hyperglycemia; and	Seizure D/O;						١
	- A prescription for F	ProAir HFA inhaler 90						١
	micrograms (mcg)/ir	nhalation, inhale 2 puffs into						
	the lungs every 6 ho	ours as needed (PRN)						
	wheezing, dated 10	/28/2019;						
	- No documentation	of a self-administration order						
	for ProAir inhaler fro	om an authorized person was						1
	present;							١
								1
	Observation at appr	roximately 2:20PM on						1
	1/15/2020 of client #	#3's bedroom revealed:						1
		as lying on top of client #3's						
	desk;	ble container present to						1
	securely store clien	cable container present to						1
	securely store clien	t #3 \$ Medication.						
	Intonious on 1/15/	2020 and 1/16/2020 with client						
	#3 revealed:	2020 and 11 10/2020 than shows					1	1
		naving used the ProAir inhaler;						
1	- Client #3 declined	to answer questions about						
	where she had obta	ained the inhaler.						
								- 1
	Interview on 1/17/2	020 with staff #1 revealed:						-
	- Medications were	supposed to be stored in the						
	locked medication	cabinet in the staff office;						
	- Client #3 had the	ProAir inhaler in her						
	possession since b	pefore staff #1 had started						
	working at the facil	ity in September 2019;						
	- Client #3 rarely us	sed the inhaler.						

Division of Health Service Regulation

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	3) DATE SURVEY COMPLETED					
		MHL034-288	B. WING		01/24/2020				
NAME OF F	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE								
INDEPEN	IDENT LIVING GROUP HO	ME AT OLD SALISE	SALISBURY F						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC 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 120	Interview on 1/16/202 (HM) revealed:  - The HM did not know ProAir inhaler in her b - Client #3 probably of local hospital when sh Interview on 1/17/2020 Professional (QP) reve-Client #3 may have be following treatment at Interview on 1/17/2020 Director/Co-Owner reve-Client #3's ProAir inh stored securely in the state of the sta	o with the House Manager of that client #3 had the edroom; otained the inhaler from a e received treatment there.  of with the Qualified ealed: orought the inhaler home a local hospital.  of with the realed: aler should have been	V 120		12/200				
	Verification  G.S. §131E-256 HEAL REGISTRY  (d2) Before hiring health care facility or shealth care facility shall Personnel Registry and of access in the appropriate of access in the access in the appropriate of access in the access in	TH CARE PERSONNEL  th care personnel into a ervice, every employer at a I access the Health Care It shall note each incident oriate business files.  The evidenced by: The shall note each incident oriate business files.  The evidence business files incident oriate business files.		Prior to hire the agency will do a healthcare personnel registry theok. The openand agency director will be responsible for ensuring the this is done and this will be ongoing.	ole				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  MHL034-288  STREET ADDRESS, CITY, STATE, JIP CODE 2415 OLD SALISBURY ROAD WINSTON-SALEM, NO 27137  V131 Continued From page 3  V131  Review on 1/16/2020 of staff #1's employee record revealed The OP was responsible for completing HCPR chacks; - He thought that he had five business days following the hire date to access the HCPR. Interview on 1/17/2020 with the Director/Co-Owner (DICO) revealed: - The OP was responsible for completing HCPR chacks; - He thought that he had five business days following the hire date to access the HCPR. Interview on 1/17/2020 with the Director/Co-Owner (DICO) revealed: - The OP was responsible for completing HCPR chacks; - He thought that he had five business days following the hire date to access the HCPR. Interview on 1/17/2020 with the Director/Co-Owner (DICO) revealed: - The D/CO and QP worked as a team to complete pre-hire background and HCPR checks.  V 738  27G .0303(c) Facility and Grounds Maintenance 10A NCAC 27G .0303 LOCATION AND EXTERIOR RECUIRDEMENTS (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.  This Rule is not met as evidenced by: Based on record reviews, observations and interviews, the facility was not maintained in a safe, clean, attractive and orderly manner. The findings are: Review on 1/16/2020 of client #1's record  RMHL034-288  STREET ADDRESS, CITY, STATE, JIP CODE  ANDRESCA, CITY STATE, JIP CODE  OAS ALEPRANCED TO HAR APPROPRIATE  PREFIX  PREFIX  PREFIX  PROVIDERS PLAN OF CORRECTION  SALES NAME PROVIDERS PREFIXED  GROSS-REPERCECTON SOLUDIES  BEACH CORRECTION  SALES NAME PROVIDERS PREFIXED  GROSS-REPERCECTON SOLUDIES  DATE OF CORRECTION  SALES NAME PROVIDERS PREFIXED  OAS ALEPRANCED TO HAR APPROPRIATE  TAG  OAS ALEPRANCED TO HAR APPROPRIATE  COMPLETED  OAS ALEPRANCED TO HAR APPROPRIATE  OAS ALEPRANCED TO HAR APPROP	Division of	Health Service Regu	lation			CONCERNICATION	(X3) DATE SURV	/EY
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Review on 1/16/2020 of client #1's record						DWNer of the	/	
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Division of Health Service Regulation FORM APPROVED							
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		MHL034-288	B. WING		01/24/2020		
NAME OF	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, S	TATE, ZIP CODE			
INDEPEN	IDENT LIVING GROUP HO	INIE AT ULU SALISE	D SALISBURY				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE		
	- Admission date: 7/13 - Diagnoses: Major Derecurrent, moderate; Stype; Post Traumatic S	pressive Disorder (D/O), Schizoaffective D/O, bipolar Stress Disorder (PTSD); Disabilities; Allergy to Docaine Abuse; Seizure Flux; pounds.  of client #2's record  5/2017; Control D/O; Mild Schizoaffective D/O; Mild Schizoaffe	V 736	responsibled for ensuring that the is done.	1/24/2020		

Division o	f Health Service Regu	lation		NETRUCTION	(3) DATE SURVEY
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		COMPLETED	
AND PLAN O	F CORRECTION	DEMINION NO.	A. BUILDING:		
			B. WING		01/24/2020
		MHL034-288	D. VVIIVO		UILTILULU
NAME OF PE	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	ZIP CODE	
		AT OLD OAL IO!	D SALISBURY ROA		1
INDEPEND	DENT LIVING GROUP H	OME AT OLD SALISE WINSTO	N-SALEM, NC 271		
(X4) ID	SUMMARY ST	FATEMENT OF DEFICIENCIES	1D	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B	(X5) COMPLETE
PREFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA	ATE DATE
TAG	REGULATORT OR	ESCIDENTI TING IN GIAM WISH		DEFICIENCY)	
		-	V 736		
V 736	Continued From pag		1		
		)) and Landlord sent text			
	messages to each o	ther;			
	From the CO to the	Landlord: "Hey [Landlord] the			
	floors at Old Salisbu	ry Rd (road) still need to be			
	fixed they are about	to fall in. Falling in the living			
	room and kitchen ar	ea and I know one bedroom";			
		Which bedroom front or			
	back" From the CO: "From	pri			
		"Will address ASAP"			
	From the CO: "Okay				
	Trom the co. chaj				
	Observation of the f	acility at approximately			
	2:20PM on 1/15/202	20 revealed:			
	- The boards on the	living room floor near the			
	front window beside	the couch were broken and			
	sagging over an are	ea approximately 3 x 2 feet;			
	- One of the broken	boards dipped down			
	approximately 1-1	½ inches exposing the			
	underlying crawispa	ace and adjacent floor joist; , the boards surrounding the	1		
1	broken area felt spo	and made a			
	creaking/breaking r				
	- Client #1's bedroo	m had clothing piled on the			
	floor, the bed sheet	s were awry and appeared			
	dirty, and there wer	re cracks in the ceiling paint			
	and drywall;				
	- Client #2's bedroo	om had dirty clothing and			
	Transfer of the second of the	with a strong body/foot odor			
	present;	d black holidum proport on the			
	- The bathroom ha	d black buildup present on the			
	snower walls and g	rout, a heavy layer of dust on vent, and had cracked,			
	hubbled and neeling	ng paint on the ceiling;			
	- The kitchen cahir	nets were dirty with unidentified			
	debris inside the ca				
	- There was trash	scattered in the yard.			
1	Interview on 1/15/2	2020 with client #1 revealed:			
	- Client #1 did not	know when or how the boards			

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PRINTED: 01/30/2020 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: A. BUILDING: \_ COMPLETED B. WING MHL034-288 01/24/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2415 OLD SALISBURY ROAD INDEPENDENT LIVING GROUP HOME AT OLD SALISE WINSTON-SALEM, NC 27127 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE **DEFICIENCY**) V 736 Continued From page 6 V 736 in the living room had been broken; - The Co-Owner (CO) had been trying to locate a different location for the facility to move to. Interview on 1/15/2020 with client #2 revealed: - The boards in the living room had been broken "for a while," but could not specify when they were broken; - The boards were possibly broken when people walked on them; - "It's a weak spot in the floor." - There had been a hole in client #2's bedroom floor, but it had already been repaired; - Facility management was trying to locate a different house to move the facility to. Interview on 1/15/2020 with client #3 revealed: - "I have no idea" how or when the boards in the living room were broken; - "I stepped on it and felt it going down, so I stepped off it ..." Interview on 1/17/2020 with staff #1 revealed: - The boards on the living room floor had possibly been broken since November of 2019; - Staff #1 did not know what had caused the boards to break, but the facility's clients did "walk a bit heavy ..." - No one had fallen through the broken boards; - The facility was "pretty old" and possibly needed

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more floor panels:

(HM) revealed:

dipped when walked upon.

room floor boards were broken;

- There were areas where the floor felt like it

Interview on 1/16/2020 with the House Manager

- The CO had been talking to the Landlord about making repairs to the floor since November 2019;

- The HM did not know when or how the living

Division of Health Service Regulation (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: \_ 01/24/2020 B. WING MHL034-288 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2415 OLD SALISBURY ROAD INDEPENDENT LIVING GROUP HOME AT OLD SALISE WINSTON-SALEM, NC 27127 PROVIDER'S PLAN OF CORRECTION (X5) SUMMARY STATEMENT OF DEFICIENCIES COMPLETE (EACH CORRECTIVE ACTION SHOULD BE (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL CROSS-REFERENCED TO THE APPROPRIATE DATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) V 736 V 736 Continued From page 7 - Clients were not allowed to walk in the area where the boards were broken; The HM did not have a more recent County Sanitation Report than the 10/5/2018 report. Interview on 1/17/2020 with the Qualified Professional (QP) revealed: - The CO coordinated repairs at the facility; - The QP visited the facility approximately weekly, but did not complete a walk-through inspection; - Facility staff were supposed to ensure the facility was cleaned and let the QP or the CO know if any repairs needed to be completed. Interview on 1/16/2020 with the CO revealed: - The CO had contacted the Landlord in November 2019 to request that the living room floor be repaired because it was "spongy." - The CO had completed some repairs himself, but could not complete all of them; - The CO had inspected under the house, and the floor joists looked "okay"; - There was subfloor material under the floor, but the subfloor was thin; - The CO did not realize that the boards in the living room had completely broken through; - The CO would immediately place a piece of plywood over the broken boards to prevent anyone from falling through the floor; - The CO would contact the Landlord immediately to coordinate repair of the floor; - The facility did not have an annual County Sanitation inspection in 2019; The CO would ensure that the facility was cleaned and that any other needed repairs were completed. - The facility's management team had been looking for another house to move the facility to but had not yet located one.

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PRINTED: 01/30/2020 FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING: COMPLETED B. WING MHL034-288 01/24/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2415 OLD SALISBURY ROAD INDEPENDENT LIVING GROUP HOME AT OLD SALISE WINSTON-SALEM, NC 27127 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) V 736 Continued From page 8 V 736 Interview on 1/17/2020 with the Director/Co-Owner (D/CO) revealed: - The CO was responsible for repairs at the facility. Review on 1/17/2020 of the Plan of Protection dated 1/17/2020 written by the D/CO revealed: - "What will you immediately do to correct the above rule violations in order to protect clients from further risk or additional harm? The agency has secured the floor with plywood temporarily and made contact with the homeowner (the Landlord) to make the necessary repairs to the floors. - Describe your plans to make sure the above happens. The agency will be in frequent contact with the homeowner over the next 3-5 business days in reference to the repairs. If the homeowner does not have someone out to start the repairs within the next week, we will find a licensed contractor and have the necessary repairs done. [The Co-Owner] will be in charge of ensuring the repairs are completed." The clients at the facility were adults with mild to moderate intellectual/developmental disabilities, medical issues including seizure disorders and

Division of Health Service Regulation

morbid obesity, and a variety of mental health diagnoses including depression, schizoaffective D/O, PTSD, ADHD; intermittent explosive D/O; oppositional defiant D/O; and impulse control D/O. The clients' body weights ranged from 226 to 365 pounds. Household cleanliness and repair

needs had been identified but remained

unresolved. In November of 2019, the Co-Owner had informed the Landlord that floor areas needed repair as they were about to fall in. No repairs to the living room floor had been completed. The floor in the living room had

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:			
			B. WING		04/24/2020
		MHL034-288	B. WING		01/24/2020
NAME OF PE	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STATE,	ZIP CODE	
INDEDENI	ENT LIVING GROUP HO	OME AT OLD SALISE	SALISBURY ROA		
INDEPENL	DENT LIVING GROUP HO	WINSTON	I-SALEM, NC 271		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE
V 736	Continued From page	e 9	V 736		
	weakened areas with	boards broken to the extent			
	that the underlying cr	rawlspace and floor joists			
	could be seen. The	severely weakened floor			
	boards in the living ro	oom would likely not sustain clients should they walk on			
	the damaged areas.	This deficiency constitutes a			
	Type A2 rule violation	n for substantial risk of			
		ust be corrected within 23			
	days. An administrat	ive penalty of \$500.00 is tion is not corrected within 23			
	days, an additional a	administrative penalty of			
	\$500.00 per day will	be imposed for each day the			
	facility is out of comp	oliance beyond the 23rd day.			

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