Division of Health Service Regulation

	FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER			CONSTRUCTION		SURVEY PLETED
		MHL029024		B. WING		03	/05/2020
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
TUE WOD	WOLLOD OF DAMPOON	000UD HOME #4 N	509 SHOAF	STREET			
THE WOR	KSHOP OF DAVIDSON-	GROUP HOME #1 -W	LEXINGTO	N, NC 27292			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FU LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
V 000	INITIAL COMMENTS	3		V 000			
	2020. The complaint unsubstantiated. A de This facility is license category: 10A NCAC	ras completed on March (Intake #NC00161306) eficiency was cited. d for the following service 27G .5600C Supervise Developmental Disabilit	was ce d				
V 290	27G .5602 Supervise	ed Living - Staff		V 290			
	of this Rule shall be denable staff to responseds. (b) A minimum of on present at all times we premises, except who habilitation plan docucapable of remaining without supervision. as needed but not less the client continues to the client continues to the home or communication specified periods of times of the client continues to the home or communication of the client continues to the home or communication of the client periods of times of the client periods of the client or adolescent of the clients present of the clients present. How present during sleeping emergency back-up the governing body; (c) children or developmental disability.	above the minimum Paragraphs (b), (c) and determined by the facility and to individualized client e staff member shall be when any adult client is often the client's treatment aments that the client is in the home or commun The plan shall be review as than annually to ensure to be capable of remaining the without supervision from. In a facility in the reation when more than or time. It is present: adolescents with substate and be served with a minimor every five or fewer mine and hours if specified by procedures determined the	y to it on the or nity wed ire ng in for ine inor ed be the by				

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 (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY IPLETED		
		MHL029024	B. WING		0:	3/05/2020
	ROVIDER OR SUPPLIER	SROUP HOME #1 -W	DDRESS, CITY, STATE DAF STREET TON, NC 27292	ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
V 290	more clients present. need be present duril specified by the emer determined by the go (d) In facilities which diagnosis is substanc (1) at least one duty shall be trained i withdrawal symptoms secondary complicati drug addiction; and	present for every four or However, only one staff ng sleeping hours if rgency back-up procedures verning body. serve clients whose primary se abuse dependency: staff member who is on in alcohol and other drug s and symptoms of ons to alcohol and other s of a certified substance Il be available on an	V 290			
	facility staff failed to of treatment plans, their facility for specified and Deceased Client (DC clients (#2, #3 and #4 Interview on 2/25/202 Director (ED) reveale - The facility used the determination to destime for the clients - The write off time for by Group Home Coord the clients several saron - DC #1 had 2 hours of emergencies - Client #2 had up to case of emergencies	ews and interviews, the document in the clients ability to remain in the mounts of time for 1 of 1 #1) and for 3 of 3 current 1). The findings are: 20 with the Executive d: term "write off cribe their unsupervised the clients was assessed redinator (GHC) whom asked				

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STATE FORM 6899 AS1Z11 If continuation sheet 2 of 14

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLI/ IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED		
				B. WING			
		MHL029024		D. WING		03	3/05/2020
NAME OF P	ROVIDER OR SUPPLIER	S	STREET ADDR	RESS, CITY, STA	TE, ZIP CODE		
		5	509 SHOAF	STREET			
THE WOR	KSHOP OF DAVIDSON-	GROUP HOME #1 -W L	EXINGTON	I, NC 27292			
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORF	RECTION	(X5)
PREFIX TAG	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)		COMPLETE DATE
V 290	V 290 Continued From page 2			V 290			
	-Client #4 had up to o	one hour of write off time i	in				
	case of emergencies		"''				
	Review on 2/25/2020	of Deceased Client #1 ([oc				
	#1)'s record revealed	l:					
	-An admission date of	of 10/3/2019					
	_	itellectual Disability Disorc	der,				
		nital Deafness, Somatic					
		Major Depressive Disorder	r,				
		ome, Intraocular Lens					
Dislocation and Osteopo -Date of death on 2/21/20		•					
	-An assessment dated 10/3/19, noting "was born		orn				
		l spina bifida, can ambula					
		ould need constant remind					
		ly when she is turning to h					
	-	ed of body pains which cau	use				
	· ·	ner chores, will become					
		get her way, has a histor					
	-	ody pains and depression					
	due to her parents' p	r to continue outpatient					
	therapy, outreach co						
	',	nent and psychosocial					
	rehabilitation services						
		ety/somatic behaviors, with	h				
		n supports, she will be abl					
		ne placement, learn how t	to				
	develop her coping s						
		atic behaviors, family there	apy				
		ing a life transition from a					
		h her mother to group hon alk through the grief proce					
	• •	nent will help her to mainta					
	_	ibility and in the PSR, she					
		how to cope with her					
	depression and anxie	•					
		tills to stabilize her mental					
	health in the commur						
	-A treatment plan dat	ted 8/7/19 noting "will wor	k				

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Division of	<u>of Health Service Regu</u>	lation			
STATEMENT	Γ OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
			B. WING		
		MHL029024	B. WING		03/05/2020
NAME OF PI	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STA	TE. ZIP CODE	
			AF STREET	,	
THE WOR	KSHOP OF DAVIDSON-0	GROUP HOME #1 -W			
		LEXING	ON, NC 27292		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI	
TAG	INEGOLATORI ORT	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	NAIL 57.112
				,	
V 290	Continued From page	e 3	V 290		
		ring and ADL (Activities of			
		the home, her daily health			
		ill be met, will work towards			
		skills, will complete chores			
		s, will complete personal			
	hygiene tasks daily, v	vill communicate effectively			
	with people by compl	eting written communication			
	correctly for those wh	no cannot sign, will assist			
	staff in cooking a mea	al or preparing a side dish			
	for dinner, will demon				
		and interpersonal situations			
		ommit to living as healthy,			
		as possible despite medical			
		participate routinely in			
		gage in psychoeducation an			
		ervices, take medications			
		atment, will clean up after			
	mealtimes, admit and				
		actions/behaviors, this			
	included positive action				
		d chores independently, at			
		strate the ability to use			
		s effectively and safely when			
		mmit to living as health,			
		as possible despite medical maintain independence with			
		education and psychosocial			
		ill increase participating in			
		emic activities, reducing the			
		complaints, initiate at least			
		teraction with peers each			
		ood instability effects on			
	personal family and/o				
		the treatment plan of DC			
	·	in the facility for specified			
	amounts of time				
	Review on 2/26/2020	of DC #1's write-off			
	determination, dated	8/7/19, revealed:			

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-"Write Off: [DC #1] is able to stay home for two

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLI/ IDENTIFICATION NUMBER:	` ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		MHL029024	B. WING		03/05/2020
NAME OF P	ROVIDER OR SUPPLIER	S	TREET ADDRESS, CITY, STA	TE, ZIP CODE	
		5	09 SHOAF STREET		
THE WOR	RKSHOP OF DAVIDSON-	GROUP HOME #1 -W L	EXINGTON, NC 27292		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE / CROSS-REFERENCED DEFICI	ACTION SHOULD BE COMPLETE TO THE APPROPRIATE DATE
V 290	Continued From page	e 4	V 290		
	hours in case of eme	rgencies."			
	Review on 2/26/2020 revealed: -An admission date of Diagnoses of Intellect Disorder, Mild; Unspekting Migraine Headaches -An assessment date slowly but is understafacts accurately or cloin a lot of drama with boyfriend issues or is other, sometimes she issues with people are investigate to find our and then discuss with stories about people, seeking behaviors, so into doing things for head to do, will get involve places like her work a etc), needs extra sup avoid exploitation by unnecessarily or try to when there is not a remoney management in the community to a wandering, needs as dinner/meal, does no	of client #2's record of 10/1/2015 ctual Developmental ecified Mood Disorder, and Eczema ed 9/9/15 noting "Speaks andable, may not represer early, seems to get involve other females arguing abore sues being friends with ear e will not tell the truth to stand then staff have to to if anything really happened to the why she made up has a lot of attention cometimes will talk people ther that they aren't suppose d with males in inappropria area (behind the dumpster thervision in the public to men, will tell on others to get someone in trouble eal issue to report, needs skills, monitoring for safet avoid exploitation or sistance with cooking a texpress she has a proble	ed but ach art ed ed sed		
	until she gets upset, supervision in the con	mmunity to monitor for			
	easily but can also ta for her specially to ge she wants. Sexual m trying to sneak off wit was sexually abuse to mother had in the ho	can be taken advantage of lk people into doing things et food or other things that isconduct in the past by th boys when she is at wor by men who her biological me, needs to work on safe agement, cooking, doing	s rk,		

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STATEMENT OF DEFICE AND PLAN OF CORRECT		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE COMF	SURVEY LETED
			A. BUILDING:			
		MHL029024	B. WING		03.	05/2020
NAME OF PROVIDER C	R SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
THE WORKSHOP O	NE DAVIDOON A	SPOUR HOME #4 N 509 SHOA	AF STREET			
THE WORKSHOP C	PF DAVIDSON-	GROUP HOME #1 -W LEXINGTO	ON, NC 27292			
	EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETE DATE
V 290 Continu	ed From page	e 5	V 290			
chores, supervichoices sex and inappropriate and she the company of the containunct of the containunct of the completion	sion around make in decision make on occase priate or potent or po	others and requires nen as she often makes poor naking around the opposite sion put herself in ntially dangerous situations sily exploited by persons in ut supervision." ed 7/24/2019 noting "will idependent living skills, her giene needs will be met, daily avioral needs will be met, she gular prompting and/or acting with others ongoing supervision and in the community, will work evocational skills, will (household and room) courately handle spending for items independently each applies to make sure she e any specific purchases shopping independently each er housemates or try to talk s, will cook a dinner/meal at will de-clutter her room and ing agazines, clothes that are no east one time per week, will incial skills by not constantly other instructor and keeping ic situations all together and over cation with others we employers/coworkers)	V 290			

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STATE FORM 6899 AS1Z11 If continuation sheet 6 of 14

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OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		(X3) DATE SURVEY COMPLETED
		A. BUILDING: _		1
	MHL029024	B. WING		03/05/2020
ROVIDER OR SUPPLIER	STREET ADD	ORESS, CITY, STA	TE, ZIP CODE	
	509 SHOA	F STREET		
KSHOP OF DAVIDSON-C	GROUP HOME #1 -W			
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL	D BE COMPLETE
Continued From page	e 6	V 290		
-"Current abilities to so community independer alone, stays with staff talked into leaving with need assistance to concashier to give appropriately in the group home hour for emergencies functions with personner guardians. Requirestores and in the compothers and makes poor	stay alone or access the ently: Very limited time in stores, could easily be the a stranger. She would bunt out money and wait for priate change back. Can ne without staff for up to one so. She can attend social s/groups preapproved by the supervision while within munity. Can be exploited by or choices with the opposite			
revealed: -An admission date of -Diagnoses of Mild In Unspecified Hearing In Chronic Kidney Diseation -An assessment compart /6/1966 on 6/29/201 has resided at the fact non-verbal and deaf, no family, needs resided at the fact non-verbal and deaf, no family, needs resided at the fact non-verbal, in 1968 where we psychiatric hospital of history of experiencing periods of agitation, for the recall events or synthesis being hospitalized at foster care, her deafin language make it diffir relationships outside	f 7/6/1966 tellectual Disabilities, Loss, Unspecified Ear, ase, Stage 3 and Arthritis pleted post intake of 5, noting "needs housing, cility for over 50 years, is assistance with safety, has dential and vocational stance with language ons due to being deaf and vas hospitalized at [a state on two occasions, has a ag anxiety, restlessness and ull scale IQ of 52, is unable emptoms that resulted in her the time, was raised in tess and use of sign cult for her to form close of the deaf community, has			
	ROVIDER OR SUPPLIER SUMMARY ST. (EACH DEFICIENC REGULATORY OR I Continued From page determination, dated -"Current abilities to scommunity independe alone, stays with staft talked into leaving with need assistance to cocashier to give approstay in the group horn hour for emergencies functions with person her guardians. Requistores and in the comothers and makes posex and should be memen." Review on 2/26/2020 revealed: -An admission date ould be not a community in the group horn hour for emergencies functions with person her guardians. Requistores and in the comothers and makes posex and should be memen." Review on 2/26/2020 revealed: -An admission date ould be not a community in the group horn in the fact of the properties of the fact of the properties of the fact of the properties of t	MHL029024 ROVIDER OR SUPPLIER KSHOP OF DAVIDSON-GROUP HOME #1 -W SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 6 determination, dated 7/24/19, revealed: -"Current abilities to stay alone or access the community independently: Very limited time alone, stays with staff in stores, could easily be talked into leaving with a stranger. She would need assistance to count out money and wait for cashier to give appropriate change back. Can stay in the group home without staff for up to one hour for emergencies. She can attend social functions with persons/groups preapproved by her guardians. Requires supervision while within stores and in the community. Can be exploited by others and makes poor choices with the opposite sex and should be monitored in situations with men." Review on 2/26/2020 of client #3's record	ROVIDER OR SUPPLIER KSHOP OF DAVIDSON-GROUP HOME #1-N SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 6 determination, dated 7/24/19, revealed: "Current abilities to stay alone or access the community independently: Very limited time alone, stays with staff in stores, could easily be talked into leaving with a stranger. She would need assistance to count out money and wait for cashier to give appropriate change back. Can stay in the group home without staff for up to one hour for emergencies. She can attend social functions with persons/groups preapproved by her guardians. Requires supervision while within stores and in the community. Can be exploited by others and makes poor choices with the opposite sex and should be monitored in situations with men." Review on 2/26/2020 of client #3's record revealed: -An admission date of 7/6/1966 -Diagnoses of Mild Intellectual Disabilities, Unspecified Hearing Loss, Unspecified Ear, Chronic Kidney Disease, Stage 3 and Arthritis -An assessment completed post intake of 7/6/1966 on 6/29/2015, noting "needs housing, has resided at the facility for over 50 years, is non-verbal and deaf, assistance with language barriers/communications due to being deaf and non-verbal, in 1968 was hospitalized at [a state psychiatric hospital] on two occasions, has a history of experiencing anxiety, restlessness and periods of agitation, full scale IQ of 52, is unable to recall events or symptoms that resulted in her being hospitalized at the time, was raised in foster care, her deafness and use of sign language make it difficult for her to form close relationships outside of the deaf community, has relied on community support systems her entire	MHL029024 SOUNDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) COntinued From page 6 determination, dated 7/24/19, revealed: ""Current abilities to stay alone or access the community independently: Very limited time alone, stays with staff in stores, could easily be talked into leaving with a stranger. She would need assistance to count out money and wait for cashier to give appropriate change back. Can stay in the group home without staff for up to one hour for emergencies. She can attend social functions with persons/groups preapproved by her guardians. Requires supervision while within stores and in the community. Can be exploited by others and makes poor choices with the opposite sex and should be monitored in situations with men." Review on 2/26/2020 of client #3's record revealed: "An admission date of 7/6/1966 -Diagnoses of Mild Intellectual Disabilities, Unspecified Hearing Loss, Unspecified Ear, Chronic Kidney Disease, Stage 3 and Arthritis An assessment completed post intake of 7/6/1966 or 20/2/2015, noting "needs housing, has resided at the facility for over 50 years, is non-verbal and deaf, assistance with language barriers/communications due to being deaf and non-verbal, in 1968 was hospitalized at [a state psychiatric hospitali] on two occasions, has a history of experiencing anxiety, restlessness and periods of agitation, full scale [0 of 25, is unable to recall events or symptoms that resulted in her being hospitalized at the time, was raised in foster care, her deafness and use of sign language make it difficult for her to form close relationships outside of the deaf community, has relied on community support systems her entire

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING:		COMPLETED
		MHL029024	B. WING		03/05/2020
NAME OF D	ROVIDER OR SUPPLIER	STDEET VL	DRESS, CITY, STA	TE ZIR CODE	,
NAIVIE OF F	ROVIDER OR SUFFLIER		AF STREET	(IE, ZIF CODE	
THE WOR	KSHOP OF DAVIDSON-	GROUP HOME #1 -W	ON, NC 27292		
	OLIMANA DV. OT		<u> </u>	DDO///DEDIO DI ANI OF CODDEC	TION
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETE
V 290	Continued From page	e 7	V 290		
	navigate her needs a				
	successful in attaining a life as independent as				
		able to communicate her			
	-	ws no acute impairment of			
		nto her needs. She is at risk			
	and trustworthy supp	ntage of without a reliable			
		ed 1/10/2020 noting "will			
		ommunity, daily living and			
		ly Living) skills in the home			
	`	daily health and medical			
	_	r daily supervision and			
		be met. She requires			
		ely crossing the streets and			
	parking lots, requires	· -			
		nunicating with strangers,			
	_	voiding exploitation, etc.,			
	requires supports in r	efraining from becoming			
	upset or having an ou	utburst when someone is			
		to her, requires reminders			
		semates to refrain from			
	· ·	requires supervision to			
		not exhaust herself from			
		engthening her vocational			
	•	rrectly completing written			
		week independently, will			
		ctronic/communication			
	-	ependently, will refrain from			
	interrupting staff during	-			
	assisting others with money/or doing pape				
		independently, will refrain			
		o doing other housemates'			
		nstrate proper social skills			
		th her peers when engaged			
	in group work/activitie				
		the treatment plan of client			
		in the facility for specified			
	amounts of time	are received for opcomed			
	aniounto or timo				

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	FOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA				
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	. BUILDING:	COMP	LETED
		MHL029024	B. WING		03	05/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
THE WOR	KSHOP OF DAVIDSON-	GROUP HOME #1 -W 509 SHOA	AF STREET			
THE WOR	INSTITUT OF DAVIDSON-	LEXINGT	ON, NC 27292			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCED	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
V 290	Continued From page	e 8	V 290			
		o of client #3's write-off				
	determination, dated 1/10/2020, revealed: -"Current abilities to stay alone or access the community independently: [Client #3]'s guardians allow her to stay alone for a few hours even though she has in the past worked independently					
		able to stay at the group				
	_	rs. On days that she does				
		I check in on her every two to				
		sure she is okay. She is				
	capable of accessing	•				
	responsible parties, is	s about to take therapeutic				
	leave with responsibl	e friends and have overnight				
	visits with DSS (Depa	artment of Social Services)				
	approval. She does r	not require awake staff."				
	Review on 2/26/2020	of client #4's record				
	revealed:					
	-An admission date of					
	-Diagnoses of Intelle	ctual Developmental				
	Disorder, Moderate,					
		oaffective Disorder, Bipolar				
		astroesophageal Reflux				
	Disorder and Sleep A					
		ed 1/7/1997 noting "would				
		independent, mother is her				
		tional training in community				
		aily living skills, no known				
		this time, had a history of				
		nge of 7, can follow simple ms to have an understanding				
		s, needs to increase money				
	-	eds to increase local leisure				
	_	ch is difficult to understand at				
		ears voices which appear to				
		s, needs to work on staying				
		erself and not apologizing				
		s to work on having more				
		ons with people, requires				
		of hallucinating or talk about				

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	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY PLETED
		MHL029024	B. WING		03	3/05/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STA	TE, ZIP CODE		
THE WOR	KSHOP OF DAVIDSON-0	SPOUR HOME #1 W	AF STREET			
THE WOR	ROHOF OF DAVIDOON-C	LEXINGT	ON, NC 27292			
(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 1 DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
V 290	V 290 Continued From page 9 hurting herself or others and can access time		V 290			
	_	hout staff under her write off				
		ld not be left home alone is				
	_	s of anxiety or an increase in				
	schizophrenia sympto	oms and has a history of				
	violent outbursts."					
	•	ed 5/17/19 noting "will work				
		e self-help and daily living				
	skills, money manage	earning cooking skills, needs				
		coordinating activities, work				
		giene tasks each day, needs				
		ore water, continues to need				
	supervision in public	settings for general safety				
), supervision to make sure				
		ited financially when making				
		pervision to get along with				
		complete personal hygiene				
		each day in a timely manner, exercise four times a week				
		nit soda intake each day to				
		en she goes out to eat or on				
		Il not repeat herself (or				
		each day independently,				
		food items on the stovetop				
		month independently, will				
	budget her spending	-				
		ed independently, will be				
	day for work or activit	nen it is time to leave each				
		the treatment plan of client				
		in the facility for specified				
	amounts of time	, 5600				
	Review on 2/26/2020	of client #4's write-off				
	determination, dated	5/17/19, revealed:				
		ip home without staff for 1				
		urposes, can access the				
		supervision and can attend				
	community outings wi	ith pre-approved persons."	1			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE	SURVEY LETED		
AND FLAN	OF CORRECTION	IDENTIFICATION NOWISI	EK.	A. BUILDING: _		COMF	LETED
		MHL029024		B. WING		03/	05/2020
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
THE WOR	KSHOP OF DAVIDSON-	GROUP HOME #1 -W	509 SHOAF	STREET N, NC 27292			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FU LSC 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 290	Continued From pag	e 10		V 290			
	-Lived with DC #1, cl -Had ridden the trans on 2/21/2020 -Once the van pulled clients got off the var -"I was inside the hor #4]. There were no s got there." -Sometimes facility s returned to the facility not presentWhen the clients go	sportation van to the faci onto the driveway, all 4	ility Cclient ve they vere				
	-Was hearing impairs write answers -Lived with DC #1, cl -On 2/21/2020, had r to the facility -No facility staff were when the clients exite-Had her own key to -Had gotten off the tr her key to get into the-No facility staff were the facility's doorOn occasions, facility when the clients arrive-Was not able to stat staff were not preser Interview on 2/25/202-Lived with DC #1, cl-Had ridden the trans	e present outside the face of the transportation variety ansportation van and use facility. The present when she unlocky staff were not present ved at the facility the how many times the fact.	van ility n. sed cked acility				
	-Lived with DC #1, cl -Had ridden the trans on 2/21/2020	ient #2 and client #3	ility				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED		
		MHL029024	B. WING		0:	3/05/2020
	RKSHOP OF DAVIDSON-C	509 SHO	DDRESS, CITY, STATE DAF STREET TON, NC 27292	ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
V 290	-"She has a key to the -There were no facilit outside the facility wh vanStated staff #1 arrive everyone to get into t Interview on 2/26/202 -Worked once or twic worked alone -When asked about u clients, staff #1 stated time." -"It was time when the and if staff feel they a themselves for a cert -Stated DC #1 and cli time for over one hou -Was not really sure h client #4 had for unsu -Was to be at the faci she worked -"When I got to the fa 4:00pm, the van was (clients #2, #3 and #4 [DC #1]was not." Further interviews on client #3 remained at several hoursStaff #2 was working and took two of the cl -Staff #2 returned to t Interview on 3/3/2020 -Had worked at the fa on 2/7/2020	e house and lets us in". y staff present inside or een the clients got off the ed at the facility and told the facility. 20 with staff #1 revealed: e a month at the facility and Insupervised time for the d they called it "write-off ey (the clients) can be alone, are capable of being by ain amount of time." Itent #3 had unsupervised r. now much time client #2 and apervised time. Itity by 4:00pm on the days cility on 2/21/2020 after there, the rest of the women b) were in the house and, but 3/3/2020 with client #2, 4 revealed: n, 2/7/2020, DC #1 and the facility without staff for at the facility on 2/7/2020 ients to the prom	V 290			

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	PLE CONSTRUCTION G:		(X3) DATE SURVEY COMPLETED 03/05/2020	
		MHL029024	B. WING _		03		
NAME OF E	PROVIDER OR SUPPLIER		TREET ADDRESS, CITY,	STATE ZID CODE	1 3		
NAME OF I	NOVIDER OR SOLT EIER		09 SHOAF STREET	OTATE, ZII CODE			
THE WO	RKSHOP OF DAVIDSON-0	GROUP HOME #1 -W	EXINGTON, NC 2729	92			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE A CROSS-REFERENCED T			
V 290	Continued From page	ntinued From page 12					
	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL		on for n up ity on				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		(X3) DATE SURVEY COMPLETED						
		MHL029024	B. WING		03	/05/2020					
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 509 SHOAF STREET											
THE WORKSHOP OF DAVIDSON-GROUP HOME #1 -W LEXINGTON, NC 27292											
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE					
V 290	-"Looking back, [the Cabout assessing clien have training in that a -The facility staff were inappropriate sexualizand had write off time of emergencies"[Client #2] was fine the facility and not ouget on social media a can happen with super-With client #4, "she had to only be left alone for (write-off time) is built the staff can't get to the client doesn't want to for a short time to pick used if the staff was of transportation van gonormal." -"We have already estarting in the staff can't get to the staff was of transportation van gonormal."	GHC] needed to learn more atts for write off timewe will be aware of client #2's ared behaviors around males afor up to one hour in case alone as long as she was in tof the house. She could and be inappropriate. But that	V 290								

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