

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL029024	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/05/2020
--------------------------------------------------	----------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER THE WORKSHOP OF DAVIDSON-GROUP HOME #1 -W	STREET ADDRESS, CITY, STATE, ZIP CODE 509 SHOAF STREET LEXINGTON, NC 27292
--------------------------------------------------------------------------------------	------------------------------------------------------------------------------------------

(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 March 5, 2020. The complaint (Intake #NC00161306) was unsubstantiated. 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 Disabilities.</p>	V 000	<p>V.290</p> <p>The Workshop of Davidson will institute an official policy on Unsupervised time in accordance with NCBS requirements.</p> <p>Each Group Home Resident's Record will contain an evaluation of abilities of the person served to stay in the group home and/or community without supervision.</p> <p>The plan will be Reviewed at least</p>	<p>By May 4, 2020</p>
V 290	<p>27G .5602 Supervised Living - Staff</p> <p>10A NCAC 27G .5602 STAFF</p> <p>(a) Staff-client ratios above the minimum numbers specified in Paragraphs (b), (c) and (d) of this Rule shall be determined by the facility to enable staff to respond to individualized client needs.</p> <p>(b) A minimum of one staff member shall be present at all times when any adult client is on the premises, except when the client's treatment or habilitation plan documents that the client is capable of remaining in the home or community without supervision. The plan shall be reviewed as needed but not less than annually to ensure the client continues to be capable of remaining in the home or community without supervision for specified periods of time.</p> <p>(c) Staff shall be present in a facility in the following client-staff ratios when more than one child or adolescent client is present:</p> <p>(1) children or adolescents with substance abuse disorders shall be served with a minimum of one staff present for every five or fewer minor clients present. However, only one staff need be present during sleeping hours if specified by the emergency back-up procedures determined by the governing body; or</p> <p>(2) children or adolescents with developmental disabilities shall be served with one staff present for every one to three clients</p>	V 290		

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

Alan Long Executive Director

TITLE: **Executive Director** (X6) DATE: **3/17/2020**

STATE FORM 6899 AS1Z11 **SHS-Mental Health** If continuation sheet 1 of 14

MAR 18 2020

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL029024	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/05/2020
--------------------------------------------------	----------------------------------------------------------------------------	------------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER THE WORKSHOP OF DAVIDSON-GROUP HOME #1 -W	STREET ADDRESS, CITY, STATE, ZIP CODE 509 SHOAF STREET LEXINGTON, NC 27292
--------------------------------------------------------------------------------------	------------------------------------------------------------------------------------------

(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 290	<p>Continued From page 1</p> <p>present and two staff present for every four or more clients present. However, only one staff need be present during sleeping hours if specified by the emergency back-up procedures determined by the governing body.</p> <p>(d) In facilities which serve clients whose primary diagnosis is substance abuse dependency:</p> <p>(1) at least one staff member who is on duty shall be trained in alcohol and other drug withdrawal symptoms and symptoms of secondary complications to alcohol and other drug addiction; and</p> <p>(2) the services of a certified substance abuse counselor shall be available on an as-needed basis for each client.</p> <p>This Rule is not met as evidenced by: Based on record reviews and interviews, the facility staff failed to document in the clients treatment plans, their ability to remain in the facility for specified amounts of time for 1 of 1 Deceased Client (DC #1) and for 3 of 3 current clients (#2, #3 and #4). The findings are:</p> <p>Interview on 2/25/2020 with the Executive Director (ED) revealed:</p> <ul style="list-style-type: none"> -The facility used the term "write off determination" to describe their unsupervised time for the clients -The write off time for the clients was assessed by Group Home Coordinator (GHC) whom asked the clients several safety questions -DC #1 had 2 hours of write off time in case of emergencies -Client #2 had up to one hour of write off time in case of emergencies -Client #3 had up to 8 hours of write off time 	V 290	<p>annually by the PCP team of each Resident, and will be evaluated for revision or continuance by the group home coordinator.</p> <p>The group home coordinator will ensure evaluations are completed and that unsupervised time is adequately documented in each Residents Record that it contains person served/PP/guardian signatures, and the amount of unsupervised time being approved.</p>	
-------	-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------	----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL029024	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/05/2020
--------------------------------------------------	----------------------------------------------------------------------------	------------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER THE WORKSHOP OF DAVIDSON-GROUP HOME #1 -W	STREET ADDRESS, CITY, STATE, ZIP CODE 509 SHOAF STREET LEXINGTON, NC 27292
--------------------------------------------------------------------------------------	------------------------------------------------------------------------------------------

(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 290	<p>Continued From page 2</p> <p>-Client #4 had up to one hour of write off time in case of emergencies</p> <p>Review on 2/25/2020 of Deceased Client #1 (DC #1)'s record revealed:</p> <p>-An admission date of 10/3/2019</p> <p>-Diagnoses of Mild Intellectual Disability Disorder, Spina Bifida, Congenital Deafness, Somatic Symptom Disorder, Major Depressive Disorder, Dandy Walker Syndrome, Intraocular Lens Dislocation and Osteoporosis.</p> <p>-Date of death on 2/21/2020</p> <p>-An assessment dated 10/3/19, noting "was born hearing impaired and spina bifida, can ambulate independently but would need constant reminds to turn her body slowly when she is turning to her sides, has complained of body pains which cause her to not complete her chores, will become upset if she does not get her way, has a history of anxiety due to her body pains and depression due to her parents' passing, it is highly recommended for her to continue outpatient therapy, outreach coordination services, medication management and psychosocial rehabilitation services for managing her depression and anxiety/somatic behaviors, with outreach coordination supports, she will be able to obtain a group home placement, learn how to develop her coping skills to manage her depression and somatic behaviors, family therapy would help to in making a life transition from a private residence with her mother to group home and support her to walk through the grief process, medication management will help her to maintain her mental health stability and in the PSR, she will continue to learn how to cope with her depression and anxiety and increase her independent living skills to stabilize her mental health in the community."</p> <p>-A treatment plan dated 8/7/19 noting "will work</p>	V 290	<p>The Group Home Coordinator will ensure all staff are trained in unsupervised policy and the unsupervised time determination for each person served.</p> <p>Training will be documented by staff signature on the Plan information Review Form.</p> <p>Unsup. Time Policy Documentation Review will be completed during a staff meeting</p>	
-------	----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------	----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL029024	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/05/2020
--------------------------------------------------	----------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER
THE WORKSHOP OF DAVIDSON-GROUP HOME #1 -A

STREET ADDRESS, CITY, STATE, ZIP CODE
**509 SHOAF STREET
LEXINGTON, NC 27292**

(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 290	<p>Continued From page 3</p> <p>on increasing daily living and ADL (Activities of Daily Living) skills in the home, her daily health and medical needs will be met, will work towards obtaining vocational skills, will complete chores on her assigned days, will complete personal hygiene tasks daily, will communicate effectively with people by completing written communication correctly for those who cannot sign, will assist staff in cooking a meal or preparing a side dish for dinner, will demonstrate awareness of emotions, social cues and interpersonal situations weekly, accept and commit to living as healthy, social and productive as possible despite medical condition, attend and participate routinely in therapy sessions, engage in psychoeducation an case management services, take medications and participate in treatment, will clean up after mealtimes, admit and accept personal responsibility for own actions/behaviors, this included positive actions and behaviors, performing household chores independently, at least weekly, demonstrate the ability to use household appliances effectively and safely when using, accept and commit to living as health, social and productive as possible despite medical condition, obtain and maintain independence with grooming, engage in education and psychosocial opportunities daily, will increase participating in daily social and academic activities, reducing the frequency of somatic complaints, initiate at least one positive social interaction with peers each week and describe mood instability effects on personal family and/or social life"</p> <p>-No documentation in the treatment plan of DC #1's ability to remain in the facility for specified amounts of time</p> <p>Review on 2/26/2020 of DC #1's write-off determination, dated 8/7/19, revealed: -"Write Off: [DC #1] is able to stay home for two</p>	V 290	<p>and a sign off of understanding completed. Training in policy will be implemented for new hires during orientation and at staff meeting for current employees by the Director or Asst. Director.</p>	
-------	------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------	---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL029024	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/05/2020
--------------------------------------------------	----------------------------------------------------------------------------	------------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER THE WORKSHOP OF DAVIDSON-GROUP HOME #1 -W	STREET ADDRESS, CITY, STATE, ZIP CODE 509 SHOAF STREET LEXINGTON, NC 27292
--------------------------------------------------------------------------------------	------------------------------------------------------------------------------------------

(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 290	<p>Continued From page 4</p> <p>hours in case of emergencies."</p> <p>Review on 2/26/2020 of client #2's record revealed:</p> <ul style="list-style-type: none"> -An admission date of 10/1/2015 -Diagnoses of Intellectual Developmental Disorder, Mild; Unspecified Mood Disorder, Migraine Headaches and Eczema -An assessment dated 9/9/15 noting "Speaks slowly but is understandable, may not represent facts accurately or clearly, seems to get involved in a lot of drama with other females arguing about boyfriend issues or issues being friends with each other, sometimes she will not tell the truth to start issues with people and then staff have to investigate to find out if anything really happened and then discuss with her why she made up stories about people, has a lot of attention seeking behaviors, sometimes will talk people into doing things for her that they aren't supposed to do, will get involved with males in inappropriate places like her work area (behind the dumpster, etc), needs extra supervision in the public to avoid exploitation by men, will tell on others unnecessarily or try to get someone in trouble when there is not a real issue to report, needs money management skills, monitoring for safety in the community to avoid exploitation or wandering, needs assistance with cooking a dinner/meal, does not express she has a problem until she gets upset, can be bossy, needs supervision in the community to monitor for stranger interaction, can be taken advantage of easily but can also talk people into doing things for her specially to get food or other things that she wants. Sexual misconduct in the past by trying to sneak off with boys when she is at work, was sexually abuse by men who her biological mother had in the home, needs to work on safety, personal supply management, cooking, doing 	V 290		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL029024	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/05/2020
--------------------------------------------------	----------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER THE WORKSHOP OF DAVIDSON-GROUP HOME #1 -W	STREET ADDRESS, CITY, STATE, ZIP CODE 509 SHOAF STREET LEXINGTON, NC 27292
--------------------------------------------------------------------------------------	------------------------------------------------------------------------------------------

(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 290	<p>Continued From page 5</p> <p>chores, not bossing others and requires supervision around men as she often makes poor choices in decision making around the opposite sex and has on occasion put herself in inappropriate or potentially dangerous situations and she could be easily exploited by persons in the community without supervision."</p> <p>-A treatment plan dated 7/24/2019 noting "will work on increasing independent living skills, her daily medical and hygiene needs will be met, daily supervision and behavioral needs will be met, she continues to need regular prompting and/or counseling with interacting with others appropriately, needs ongoing supervision and monitoring if working in the community, will work toward increasing prevocational skills, will complete her chores (household and room) independently, will accurately handle spending money while paying for items independently each day, will check her supplies to make sure she doesn't need to make any specific purchases before she goes out shopping independently each week, will not boss her housemates or try to talk them into doing things, will cook a dinner/meal at least twice a month, will de-clutter her room and closet of trash/emptying containers/papers/magazines, clothes that are no longer wearable, at least one time per week, will demonstrate good social skills by not constantly telling on her peers to her instructor and keeping herself out of dramatic situations all together and will demonstrate proper interaction/communication with others (strangers/prospective employers/coworkers) independently each day."</p> <p>-No documentation in the treatment plan of client #2's ability to remain in the facility for specified amounts of time</p> <p>Review on 2/26/2020 of client #2's write-off</p>	V 290		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL029024	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/05/2020
--------------------------------------------------	----------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER THE WORKSHOP OF DAVIDSON-GROUP HOME #1 -W	STREET ADDRESS, CITY, STATE, ZIP CODE 509 SHOAF STREET LEXINGTON, NC 27292
--------------------------------------------------------------------------------------	------------------------------------------------------------------------------------------

(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 290	<p>Continued From page 6</p> <p>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."</p> <p>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 safety, has no family, needs residential and vocational supports, needs 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 life, the supports in place have helped her</p>	V 290		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL029024	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/05/2020
--------------------------------------------------	----------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER THE WORKSHOP OF DAVIDSON-GROUP HOME #1 -A	STREET ADDRESS, CITY, STATE, ZIP CODE 509 SHOAF STREET LEXINGTON, NC 27292
--------------------------------------------------------------------------------------	------------------------------------------------------------------------------------------

(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 290	<p>Continued From page 7</p> <p>navigate her needs and helped her to be successful in attaining a life as independent as she can manage, is able to communicate her preferences and shows no acute impairment of insight or judgment into her needs. She is at risk for being taken advantage of without a reliable and trustworthy support system."</p> <p>-A treatment plan dated 1/10/2020 noting "will work on increasing community, daily living and ADL (Activities of Daily Living) skills in the home and community, her daily health and medical needs will be met, her daily supervision and behavioral needs will be met. She requires supervision while safely crossing the streets and parking lots, requires assistance in the community with communicating with strangers, ordering foods and avoiding exploitation, etc., requires supports in refraining from becoming upset or having an outburst when someone is explaining something to her, requires reminders when upset with housemates to refrain from physical altercations, requires supervision to ensure that she does not exhaust herself from over working and strengthening her vocational skills, will practice correctly completing written communication each week independently, will correctly operate electronic/communication devices each day independently, will refrain from interrupting staff during the times they are assisting others with medications/counting money/or doing paper work unless it is an emergency each day independently, will refrain from being talked into doing other housemates' chores and will demonstrate proper social skills by communicating with her peers when engaged in group work/activities."</p> <p>-No documentation in the treatment plan of client #3's ability to remain in the facility for specified amounts of time</p>	V 290		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL029024	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/05/2020
--------------------------------------------------	----------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER THE WORKSHOP OF DAVIDSON-GROUP HOME #1 -A	STREET ADDRESS, CITY, STATE, ZIP CODE 509 SHOAF STREET LEXINGTON, NC 27292
--------------------------------------------------------------------------------------	------------------------------------------------------------------------------------------

(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 290	<p>Continued From page 8</p> <p>Review on 2/26/2020 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 in the community, is able to stay at the group home for up to 8 hours. On days that she does not feel well, staff will check in on her every two to three hours to make sure she is okay. She is capable of accessing the community with responsible parties, is about to take therapeutic leave with responsible friends and have overnight visits with DSS (Department of Social Services) approval. She does not require awake staff."</p> <p>Review on 2/26/2020 of client #4's record revealed: -An admission date of 1/6/1997 -Diagnoses of Intellectual Developmental Disorder, Moderate, Schizophrenia/Schizoaffective Disorder, Bipolar Type, Unspecified, Gastroesophageal Reflux Disorder and Sleep Apnea -An assessment dated 1/7/1997 noting "would like to become more independent, mother is her guardian, wants additional training in community inclusion skills and daily living skills, no known medical problems at this time, had a history of seizures before the age of 7, can follow simple instructions and seems to have an understanding of simple instructions, needs to increase money management and needs to increase local leisure resources, her speech is difficult to understand at times, occasionally hears voices which appear to be triggered by stress, needs to work on staying calm, not repeating herself and not apologizing repeatedly and needs to work on having more appropriate interactions with people, requires monitoring for signs of hallucinating or talk about</p>	V 290		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL029024	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/05/2020
--------------------------------------------------	----------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER THE WORKSHOP OF DAVIDSON-GROUP HOME #1 -A	STREET ADDRESS, CITY, STATE, ZIP CODE 509 SHOAF STREET LEXINGTON, NC 27292
--------------------------------------------------------------------------------------	------------------------------------------------------------------------------------------

(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 290	<p>Continued From page 9</p> <p>hurting herself or others and can access time alone in the home without staff under her write off agreements but should not be left home alone is she is exhibiting signs of anxiety or an increase in schizophrenia symptoms and has a history of violent outbursts."</p> <p>-A treatment plan dated 5/17/19 noting "will work towards learning more self-help and daily living skills, money management skills, needs to continue to work on learning cooking skills, needs regular assistance in coordinating activities, work on completing her hygiene tasks each day, needs reminders to drink more water, continues to need supervision in public settings for general safety (crossing streets, etc.), supervision to make sure she isn't getting exploited financially when making purchases, needs supervision to get along with her housemates, will complete personal hygiene tasks independently each day in a timely manner, will do some form of exercise four times a week independently, will limit soda intake each day to only having them when she goes out to eat or on special occasions, will not repeat herself (or apologize repeatedly) each day independently, will prepare a dinner food items on the stovetop or in the over twice a month independently, will budget her spending money each week to purchase items or need independently, will be dressed and ready when it is time to leave each day for work or activities"</p> <p>-No documentation in the treatment plan of client #4's ability to remain in the facility for specified amounts of time</p> <p>Review on 2/26/2020 of client #4's write-off determination, dated 5/17/19, revealed: -"Can stay in the group home without staff for 1 hour for emergency purposes, can access the community with staff supervision and can attend community outings with pre-approved persons."</p>	V 290		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL029024	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/05/2020
--------------------------------------------------	----------------------------------------------------------------------------	------------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER THE WORKSHOP OF DAVIDSON-GROUP HOME #1 -W	STREET ADDRESS, CITY, STATE, ZIP CODE 509 SHOAF STREET LEXINGTON, NC 27292
--------------------------------------------------------------------------------------	------------------------------------------------------------------------------------------

(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 290	<p>Continued From page 10</p> <p>Interview on 2/25/2020 with client #2 revealed: -Lived with DC #1, client #3 and client #4 -Had ridden the transportation van to the facility on 2/21/2020 -Once the van pulled onto the driveway, all 4 clients got off the van. -"I was inside the house with [client #3] and [client #4]. There were no staff at the house when we got there." -Sometimes facility staff were present when they returned to the facility and sometimes, they were not present. -When the clients got to the facility and no staff are present, "we are supposed to go inside and wait."</p> <p>Interview on 2/25/2020 with client #3 revealed: -Was hearing impaired but could read lips and write answers -Lived with DC #1, client #2 and client #4 -On 2/21/2020, had ridden the transportation van to the facility -No facility staff were present outside the facility when the clients exited the transportation van. -Had her own key to the facility -Had gotten off the transportation van and used her key to get into the facility. -No facility staff were present when she unlocked the facility's door. -On occasions, facility staff were not present when the clients arrived at the facility -Was not able to state how many times the facility staff were not present.</p> <p>Interview on 2/25/2020 with client #4 revealed: -Lived with DC #1, client #2 and client #3 -Had ridden the transportation van to the facility on 2/21/2020 -Stated client #3 was the first person off the van.</p>	V 290		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL029024	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/05/2020
--------------------------------------------------	----------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER THE WORKSHOP OF DAVIDSON-GROUP HOME #1 -A	STREET ADDRESS, CITY, STATE, ZIP CODE 509 SHOAF STREET LEXINGTON, NC 27292
--------------------------------------------------------------------------------------	------------------------------------------------------------------------------------------

(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 290	<p>Continued From page 11</p> <ul style="list-style-type: none"> - "She has a key to the house and lets us in". - There were no facility staff present inside or outside the facility when the clients got off the van. - Stated staff #1 arrived at the facility and told everyone to get into the facility. <p>Interview on 2/26/2020 with staff #1 revealed:</p> <ul style="list-style-type: none"> - Worked once or twice a month at the facility and worked alone - When asked about unsupervised time for the clients, staff #1 stated they called it "write-off time." - "It was time when they (the clients) can be alone, and if staff feel they are capable of being by themselves for a certain amount of time." - Stated DC #1 and client #3 had unsupervised time for over one hour. - Was not really sure how much time client #2 and client #4 had for unsupervised time. - Was to be at the facility by 4:00pm on the days she worked - "When I got to the facility on 2/21/2020 after 4:00pm, the van was there, the rest of the women (clients #2, #3 and #4) were in the house and, but [DC #1] was not." <p>Further interviews on 3/3/2020 with client #2, client #3 and client #4 revealed:</p> <ul style="list-style-type: none"> - The night of the prom, 2/7/2020, DC #1 and client #3 remained at the facility without staff for several hours. - Staff #2 was working at the facility on 2/7/2020 and took two of the clients to the prom - Staff #2 returned to the facility after 9pm <p>Interview on 3/3/2020 with staff #2 revealed:</p> <ul style="list-style-type: none"> - Had worked at the facility the night of the prom on 2/7/2020 - Had asked the GHC about unsupervised time for 	V 290		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL029024	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/05/2020
--------------------------------------------------	----------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER THE WORKSHOP OF DAVIDSON-GROUP HOME #1 -A	STREET ADDRESS, CITY, STATE, ZIP CODE 509 SHOAF STREET LEXINGTON, NC 27292
--------------------------------------------------------------------------------------	------------------------------------------------------------------------------------------

(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 290	<p>Continued From page 12</p> <p>two of the clients that were not attending the prom -"I was told by [the GHC] that [DC #1] had 4 hours of write-off time and [client #3] had 8 hours of write-off time." -Had left the facility around 4:30pm on 2/7/2020 and returned that night at approximately 9:15pm</p> <p>Interview on 2/28/2020 with the GHC revealed: -She was responsible for assessing the clients for unsupervised time -The facility used the term "write off time" for unsupervised time. -There was a list of questions each client was asked to assess them for unsupervised time. -Was also responsible for writing the clients' treatment plans and ensuring the treatment plan was based on their assessments. -Client #3 had 8 hours of unsupervised time in her treatment plan -"The other clients could stay at the facility for up to one hour or two hours for emergency purposes. -"Let's say staff is running late, has a wreck or something, then the clients can stay at the facility until the backup staff arrives...if staff had to run out for an errand or a short trip, [DC #1] could stay alone, especially if she did not want to go on the errand."</p> <p>Further interview on 2/28/2020 with the ED revealed: -Write off determination was developed to ensure the clients knew safety signs, what to do if the house catches fire and who to call during emergencies. -DC #1 was very independent and that was "hard to show on paper" "[DC #1] had some write-off time in case of emergencies."</p>	V 290		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL029024	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/05/2020
--------------------------------------------------	----------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER THE WORKSHOP OF DAVIDSON-GROUP HOME #1 -W	STREET ADDRESS, CITY, STATE, ZIP CODE 509 SHOAF STREET LEXINGTON, NC 27292
--------------------------------------------------------------------------------------	------------------------------------------------------------------------------------------

(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 290	<p>Continued From page 13</p> <p>-"Looking back, [the GHC] needed to learn more about assessing clients for write off time...we will have training in that area."</p> <p>-The facility staff were aware of client #2's inappropriate sexualized behaviors around males and had write off time for up to one hour in case of emergencies.</p> <p>-"[Client #2] was fine alone as long as she was in the facility and not out of the house. She could get on social media and be inappropriate. But that can happen with supervision ..."</p> <p>-With client #4, "she has schizophrenia and was to only be left alone for emergency purposes. It (write-off time) is built into her plan just in case the staff can't get to the facility right at 4pm or if a client doesn't want to go into the community say for a short time to pick up medications. It is also used if the staff was caught in traffic or if the transportation van got to the facility earlier than normal."</p> <p>-"We have already established that [staff #1] was not at the facility when the clients got off the van on 2/21/2020."</p>	V 290		



Vocational & Life Skills Training
for Adults with Disabilities

March 17, 2020

Laura Rodriguez
Facility Compliance Consultant I
Mental Health Licensure and Certification Section
NC Division of Health Service Regulation
2718 Mail Service Center
Raleigh, NC 27699-2718

Dear Ms. Rodriguez:

Please find enclosed the plan of correction required per your complaint survey completed March 5, 2020 at The Workshop of Davidson Group Home #1. Thank you for your assistance during this review.

Sincerely,

Kara Cody
Executive Director

Mailing Address
P.O. Box 906
Lexington, NC 27293-0906

Location:
275 Monroe Road
Lexington, NC 27292

Group Homes
228 West Ninth Street, Lexington, NC
509 Shoaf Street, Lexington, NC

Telephone: (336) 248-2816
Fax: (336) 248-4995
Email: info@workshopofdavidson.org
www.workshopofdavidson.org