	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
		IDENTIFICATION NOMBER.	A. BUILDING:			
		MHL032-423	B. WING		09	C 0/24/2020
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
MELODY I	HOUSE		RLIN DRIVE M, NC 27703			
	SUMMARY ST			PROVIDER'S PLAN OF		(XE)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENT	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 000	INITIAL COMMENTS		V 000			
	24, 2020. The compl	as completed on September aint was substantiated 3). Deficiencies cited.				
	This facility is licensed for the following service category: 10A NCAC 27G. 5600A Supervised Living for Adults with Mental Illness					
V 133	G.S. 122C-80 Crimina	al History Record Check	V 133			
	CHECK REQUIRED APPLICANTS FOR E (a) Definition As us "provider" applies to a program and any pro- developmental disabi					
	provider licensed und	n offer of employment by a ler this Chapter to an tion that does not require the				
	applicant to have an o conditioned on conse criminal history record	occupational license is nt to a State and national d check of the applicant. If				
	less than five years, t is conditioned on con	n a resident of this State for hen the offer of employment sent to a State and national d check of the applicant. The pry record check shall				
	include a check of the the applicant has bee five years or more, th	e applicant's fingerprints. If en a resident of this State for en the offer is conditioned criminal history record				
	check of the applican employ an applicant v criminal history record	t. A provider shall not who refuses to consent to a d check required by this nerwise provided in this				
ision of Hea	-	e business days of making				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED	
			A. BUILDING:				
		MHL032-423	B. WING		09	C 9/24/2020	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2724 MARLIN DRIVE							
MELODY	HOUSE		ARLIN DRIVE M, NC 27703				
(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 DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
V 133	Continued From page	e 1	V 133				
	shall submit a request Justice under G.S. 11 criminal history record section or shall subm entity to conduct a St check required by this G.S. 114-19.10, the D return the results of m record checks for em covered by Public Lat Department of Health Criminal Records Che business days of reco history of the person, and Human Services Unit, shall notify the p information received of the applicant. In no national criminal histor with the provider. Pro upon request verificat check has been comp by this section. A cou appropriate local ordi the Division of Crimin may conduct on beha criminal history record section without the pr request to the Depart case, the county shall criminal history record section within five bus conditional offer of er All criminal history inf provider is confidentia except to the applicant (c) of this section. Fo	d check required by this it a request to a private ate criminal history record is section. Notwithstanding Department of Justice shall national criminal history ployment positions not w 105-277 to the and Human Services, eck Unit. Within five eipt of the national criminal the Department of Health , Criminal Records Check provider as to whether the may affect the employability to case shall the results of the pry record check be shared widers shall make available tion that a criminal history poleted on any staff covered inty that has adopted an nance and has access to hal Information data bank alf of a provider a State d check required by this rovider having to submit a ment of Justice. In such a I commence with the State d check required by this siness days of the mployment by the provider. formation received by the al and may not be disclosed, ant as provided in subsection					

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
			A. BUILDING:			
	MHL032-423		B. WING		09	C / 24/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE		
MELODY	HOUSE		ARLIN DRIVE M, NC 27703			
(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 COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
V 133	Continued From page	e 2	V 133			
	records obtained from (c) Action If an app record check reveals a relevant offense, th of the following factor hire the applicant: (1) The level and seri (2) The date of the cr (3) The age of the pe conviction. (4) The circumstance commission of the cri (5) The nexus betwee the person and the jo filled. (6) The prison, jail, pr rehabilitation, and em person since the date (7) The subsequent of a relevant offense. The fact of conviction shall not be a bar to e listed factors shall be If the provider disqua consideration of the r provider may disclose the criminal history re to the disqualification of the criminal history applicant. (d) Limited Immunity. or employee of a prov complies with this sec civil liability for: (1) The failure of the individual on the basi	d checks utilizing public in a State agency. licant's criminal history one or more convictions of e provider shall consider all rs in determining whether to iousness of the crime. ime. rson at the time of the es surrounding the ime, if known. en the criminal conduct of b duties of the position to be robation, parole, hployment records of the e the crime was committed. commission by the person of of a relevant offense alone employment; however, the considered by the provider. lifies an applicant after relevant factors, then the e information contained in ecord check that is relevant , but may not provide a copy				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED
		IDENTIFICATION NOWDER.	A. BUILDING:	······		
	MHL032-423 B. WING		B. WING		09	C //24/2020
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2724 MARLIN DRIVE						
MELODY	HOUSE		ARLIN DRIVE M, NC 27703			
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V 133	Continued From page	e 3	V 133			
	criminal offenses if th history record check is compliance with this s (e) Relevant Offense "me federal criminal histor indictment of a crime, felony, that bears up have responsibility fo persons needing mer disabilities, or substa crimes include the cri any of the following A General Statutes: Art Issuing Monetary Sut Endangering Execution Article 6, Homicide; A Sex Offenses; Article Kidnapping and Abdu Injury or Damage by Incendiary Device or and Other Housebrea Other Burnings; Article Robbery; Article 18, E False Pretenses and Obtaining Property of Fraudulent Use of Cri Article 19B, Financial Act; Article 20, Fraud 26, Offenses Against Decency; Article 35, Offen Sex Office; Article 35, Offen	A - As used in this section, eans a county, state, or by of conviction or pending whether a misdemeanor or on an individual's fitness to r the safety and well-being of natal health, developmental nce abuse services. These minal offenses set forth in articles of Chapter 14 of the icle 5, Counterfeiting and ostitutes; Article 5A, we and Legislative Officers; article 7A, Rape and Other 8, Assaults; Article 10, action; Article 13, Malicious Use of Explosive or Material; Article 14, Burglary akings; Article 15, Arson and le 16, Larceny; Article 17, Embezzlement; Article 19A, * Services by False or edit Device or Other Means; Transaction Card Crime s; Article 21, Forgery; Article Public Morality and , Adult Establishments; n; Article 28, Perjury; Article I, Misconduct in Public enses Against the Public tiots and Civil Disorders; of Minors; Article 40, nily; Article 59, Public				

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STATEMENT OF DEFICIENCIES () AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			
	MHL032-423		B. WING		09	C 0/24/2020
IAME OF PF	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
IELODY I	HOUSE		RLIN DRIVE M, NC 27703			
(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 DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 133	Continued From page	e 4	V 133			
	sale of drugs in violat Controlled Substance 90 of the General Sta offenses such as sale violation of G.S. 18B- impaired in violation of G.S. 20-138.5. (f) Penalty for Furnish applicant for employin supplies, or otherwise an employment applic criminal history record shall be guilty of a Cla (g) Conditional Emplo employ an applicant of obtaining the results of check regarding the a following requirement (1) The provider shall prior to obtaining the criminal history record subsection (b) of this fingerprint cards as re (2) The provider shall criminal history record business days after th conditional employme 2001-155, s. 1; 2004- 2005-4, ss. 1, 2, 3, 4,	of G.S. 20-138.1 through ning False Information Any nent who willfully furnishes, e gives false information on cation that is the basis for a d check under this section ass A1 misdemeanor. byment A provider may conditionally prior to of a criminal history record applicant if both of the ts are met: I not employ an applicant applicant's consent for d check as required in section or the completed equired in G.S. 114-19.10. I submit the request for a d check not later than five he individual begins ent. (2000-154, s. 4; -124, ss. 10.19D(c), (h); 5(a); 2007-444, s. 3.)				
	This Rule is not met Based on record revie failed to ensure the s	ew and interview, the facility				

STATEMEN	of Health Service Regu T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:	ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		MHL032-423	B. WING			C / 24/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
IELODY	HOUSE		RLIN DRIVE M, NC 27703			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLET
V 133	Continued From page	e 5	V 133			
	the conditional offer c audited staff (#6). Th	of employment for one of one ne findings are:				
	revealed: - No Hire Date. - Job title: Habilitatior	Staff #6's personnel record Technician - As needed. nce the criminal record				
	-Confirmed the staff # check was not in the -FS #5 was responsit	ble for personnel files and background check was				
V 290	27G .5602 Supervise	d Living - Staff	V 290			
	of this Rule shall be c enable staff to respon- needs. (b) A minimum of one present at all times w premises, except whe habilitation plan docu capable of remaining without supervision. as needed but not less the client continues to the home or commun specified periods of ti (c) Staff shall be prese following client-staff r child or adolescent cl	above the minimum Paragraphs (b), (c) and (d) letermined by the facility to nd to individualized client e staff member shall be hen any adult client is on the en the client's treatment or ments that the client is in the home or community The plan shall be reviewed as than annually to ensure o be capable of remaining in ity without supervision for me. sent in a facility in the atios when more than one				

Division of Health Service Regulation STATE FORM

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
			A. BUILDING:			
		MHL032-423	B. WING		09	C / 24/2020
NAME OF PI	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE		
IELODY	HOUSE		ARLIN DRIVE M, NC 27703			
(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 CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLET DATE
V 290	Continued From page	e 6	V 290			
	of one staff present for clients present. How present during sleepi emergency back-up p the governing body; of (2) children or developmental disabi- one staff present for present and two staff more clients present. need be present durin specified by the emer determined by the go (d) In facilities which diagnosis is substance (1) at least one duty shall be trained withdrawal symptoms secondary complicati-	adolescents with lities shall be served with every one to three clients present for every four or However, only one staff ng sleeping hours if rgency back-up procedures verning body. serve clients whose primary ce abuse dependency: e staff member who is on in alcohol and other drug a and symptoms of ons to alcohol and other				
	failed to assess and o of having unsupervise treatment or habilitati	as evidenced by: ew and interview, the facility document client's capability ed time in the home in the on plan affecting one of (#1, #2, and #3). The				
	-Admission date of 8/	phrenia Disorder, Bipolar				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A BUILDING ⁻		(X3) DATE SURVEY COMPLETED C	
			A. BOILDING.			
		MHL032-423	B. WING		09	/24/2020
NAME OF PI	ROVIDER OR SUPPLIER	STREET	DDRESS, CITY, STATE	, ZIP CODE		
MELODY	HOUSE		ARLIN DRIVE M, NC 27703			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN O		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEN) THE APPROPRIATE	COMPLETE
V 290	Continued From page	e 7	V 290			
	-Treatment Plan date	d 1/2/20.				
	-The unsupervised do	ocument did not include a				
	date.					
	-Treatment plan did not include unsupervised time in the home.					
	Review on 9/22/20 of client #2's record revealed:					
	-Admission date of 10/15/17. -Diagnosis of Schizophrenia Disorder.					
	-Treatment Plan date					
		ocument did not include a				
	-Treatment plan did not include unsupervised					
	time in the home.					
	Review on 9/22/20 of client #3's record revealed:					
	-Admission date of 4/ -Diagnosis of Bipolar					
	-Treatment Plan date					
	-The unsupervised do date.	ocument did not include a				
		ot include unsupervised				
	time in the home.					
	Observation on 9/22/2	20 at 8:50 a.m. revealed:				
		sister facility across the				
		nedication and provide				
	breakfast.	eakfast at the home for both				
	facilities.					
		ister facility for 10 minutes.				
	-The Director's husba	ind came to the home until				
	the Director arrived.					
		other facility when the				
	Director's husband ar	lived.				
	Interview on 9/22/20	with Client #1 revealed:				
	-He did not go out alo					
	-He was not able to s	tay in the home				
	unsupervised due to I	his seizures.				

STATEMENT	of Health Service Regu r of Deficiencies of correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			SURVEY PLETED
			B. WING		C	
		MHL032-423			09	
NAME OF PI	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE	, ZIP CODE		
MELODY	HOUSE		ARLIN DRIVE M, NC 27703			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OI (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLET DATE
V 290	Continued From page	e 8	V 290			
	Client #4 revealed: -They were not allow unsupervised. -The Director told the unsupervised time in -Staff was always at f -They were unsuperv sister facility. Interview on 9/22/20	the home. rised when staff went to the with Staff #4 revealed:				
	Thursday. -All clients had unsup community.	.m Monday through pervised time in the wed unsupervised time in the				
	-She had to do daily thouses. -She prepared meals -She had to go acros medication. -She administered me -She was also the state- -There's a cleaner to	s the street to administered edication at 8.m. and 8 p.m. aff for the sister house.				
	and was not consider -She reported there v sister facility. -Confirmed there was					
	Interview on 9/23/20 revealed: -She was the prograr -Resigned in August -Staff #4 had to work -Staff #4 was responsed alth Service Regulation	n coordinator for the home. 2020. at both homes.				

STATE FORM

ND PLAN C	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ID PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C		(X3) DATE SURVEY COMPLETED	
			A. BUILDING:		с	
		MHL032-423	B. WING		09	9/24/2020
IAME OF PF	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	, ZIP CODE		
IELODY I	HOUSE		ARLIN DRIVE M, NC 27703			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED T(DEFICIE	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLET DATE
V 290	Continued From page	ge 9	V 290			
	homes. -Staff #4 periodically homes. -Staff #4 was support when relief staff did Interview on 9/22/20 revealed: -All clients were allo home except client # -Client #1 was not at to seizure disorder. -She and other staff staff #4 left for the d -She did not like clieft without supervision. -Staff #4 was responder.	llowed unsupervised time due worked at the home after lay. ents staying in the home				
I						