

Division of Health Service Regulation

| | | | |
|--|---|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL032-383 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____ | (X3) DATE SURVEY COMPLETED C 09/24/2020 |
|--|---|---|---|

| | |
|---|--|
| NAME OF PROVIDER OR SUPPLIER MELODY HOUSE | STREET ADDRESS, CITY, STATE, ZIP CODE 2727 MARLIN DRIVE DURHAM, NC 27703 |
|---|--|

| (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 September 24, 2020. The complaint was substantiated (Intake #NC00168853). Deficiencies 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 | | |
| V 112 | <p>27G .0205 (C-D) Assessment/Treatment/Habilitation Plan</p> <p>10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN</p> <p>(c) The plan shall be developed based on the assessment, and in partnership with the client or legally responsible person or both, within 30 days of admission for clients who are expected to receive services beyond 30 days.</p> <p>(d) The plan shall include:</p> <ol style="list-style-type: none"> (1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement; (2) strategies; (3) staff responsible; (4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both; (5) basis for evaluation or assessment of outcome achievement; and (6) written consent or agreement by the client or responsible party, or a written statement by the provider stating why such consent could not be obtained. | V 112 | | |

| | | |
|--|-------|-----------|
| Division of Health Service Regulation LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|--|-------|-----------|

Division of Health Service Regulation

| | | | |
|--|---|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL032-383 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____ | (X3) DATE SURVEY COMPLETED C 09/24/2020 |
|--|---|---|---|

| | |
|---|--|
| NAME OF PROVIDER OR SUPPLIER MELODY HOUSE | STREET ADDRESS, CITY, STATE, ZIP CODE 2727 MARLIN DRIVE DURHAM, NC 27703 |
|---|--|

| (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 112 | <p>Continued From page 1</p> <p>This Rule is not met as evidenced by: Based on record reviews and interview, the facility failed to have a current treatment plan for two of three audited clients (#1 and #2). The findings are:</p> <p>Review on 9/24/20 of Client # 1's record revealed: -Admission date of 7/31/06. -Diagnosis of Schizoaffective Disorder, Bipolar Type. -Treatment Plan expired 8/20/20. -There was no current treatment plan in the client's record.</p> <p>Review on 9/24/20 of Client # 2's record revealed: -Admission date of 4/30/07. -Diagnoses of Schizophrenia, Paranoid Type, Major Depressive Disorder and Mild Developmental Disability. -Treatment Plan expired 7/22/20. -There was no current treatment plan in the client's record.</p> <p>Interview on 9/24/20 with the Director revealed: -The day program was responsible for completing treatment plans. -Confirmed treatment plans expired for client #1 and client #2. -Confirmed she would update the treatment plans until the day programs reopen.</p> | V 112 | | |
| V 133 | <p>G.S. 122C-80 Criminal History Record Check</p> <p>G.S. §122C-80 CRIMINAL HISTORY RECORD</p> | V 133 | | |

Division of Health Service Regulation

| | | | |
|--|---|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL032-383 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____ | (X3) DATE SURVEY COMPLETED C 09/24/2020 |
|--|---|---|---|

| | |
|---|--|
| NAME OF PROVIDER OR SUPPLIER MELODY HOUSE | STREET ADDRESS, CITY, STATE, ZIP CODE 2727 MARLIN DRIVE DURHAM, NC 27703 |
|---|--|

| (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 133 | <p>Continued From page 2</p> <p>CHECK REQUIRED FOR CERTAIN APPLICANTS FOR EMPLOYMENT.</p> <p>(a) Definition. - As used in this section, the term "provider" applies to an area authority/county program and any provider of mental health, developmental disability, and substance abuse services that is licensable under Article 2 of this Chapter.</p> <p>(b) Requirement. - An offer of employment by a provider licensed under this Chapter to an applicant to fill a position that does not require the applicant to have an occupational license is conditioned on consent to a State and national criminal history record check of the applicant. If the applicant has been a resident of this State for less than five years, then the offer of employment is conditioned on consent to a State and national criminal history record check of the applicant. The national criminal history record check shall include a check of the applicant's fingerprints. If the applicant has been a resident of this State for five years or more, then the offer is conditioned on consent to a State criminal history record check of the applicant. A provider shall not employ an applicant who refuses to consent to a criminal history record check required by this section. Except as otherwise provided in this subsection, within five business days of making the conditional offer of employment, a provider shall submit a request to the Department of Justice under G.S. 114-19.10 to conduct a criminal history record check required by this section or shall submit a request to a private entity to conduct a State criminal history record check required by this section. Notwithstanding G.S. 114-19.10, the Department of Justice shall return the results of national criminal history record checks for employment positions not covered by Public Law 105-277 to the</p> | V 133 | | |

Division of Health Service Regulation

| | | | |
|--|---|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL032-383 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____ | (X3) DATE SURVEY COMPLETED C 09/24/2020 |
|--|---|---|---|

| | |
|---|--|
| NAME OF PROVIDER OR SUPPLIER MELODY HOUSE | STREET ADDRESS, CITY, STATE, ZIP CODE 2727 MARLIN DRIVE DURHAM, NC 27703 |
|---|--|

| (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 133 | <p>Continued From page 3</p> <p>Department of Health and Human Services, Criminal Records Check Unit. Within five business days of receipt of the national criminal history of the person, the Department of Health and Human Services, Criminal Records Check Unit, shall notify the provider as to whether the information received may affect the employability of the applicant. In no case shall the results of the national criminal history record check be shared with the provider. Providers shall make available upon request verification that a criminal history check has been completed on any staff covered by this section. A county that has adopted an appropriate local ordinance and has access to the Division of Criminal Information data bank may conduct on behalf of a provider a State criminal history record check required by this section without the provider having to submit a request to the Department of Justice. In such a case, the county shall commence with the State criminal history record check required by this section within five business days of the conditional offer of employment by the provider. All criminal history information received by the provider is confidential and may not be disclosed, except to the applicant as provided in subsection (c) of this section. For purposes of this subsection, the term "private entity" means a business regularly engaged in conducting criminal history record checks utilizing public records obtained from a State agency.</p> <p>(c) Action. - If an applicant's criminal history record check reveals one or more convictions of a relevant offense, the provider shall consider all of the following factors in determining whether to hire the applicant:</p> <ol style="list-style-type: none"> (1) The level and seriousness of the crime. (2) The date of the crime. (3) The age of the person at the time of the | V 133 | | |

Division of Health Service Regulation

| | | | |
|--|---|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL032-383 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____ | (X3) DATE SURVEY COMPLETED C 09/24/2020 |
|--|---|---|---|

| | |
|---|--|
| NAME OF PROVIDER OR SUPPLIER MELODY HOUSE | STREET ADDRESS, CITY, STATE, ZIP CODE 2727 MARLIN DRIVE DURHAM, NC 27703 |
|---|--|

| (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 133 | <p>Continued From page 4</p> <p>conviction.</p> <p>(4) The circumstances surrounding the commission of the crime, if known.</p> <p>(5) The nexus between the criminal conduct of the person and the job duties of the position to be filled.</p> <p>(6) The prison, jail, probation, parole, rehabilitation, and employment records of the person since the date the crime was committed.</p> <p>(7) The subsequent commission by the person of a relevant offense.</p> <p>The fact of conviction of a relevant offense alone shall not be a bar to employment; however, the listed factors shall be considered by the provider. If the provider disqualifies an applicant after consideration of the relevant factors, then the provider may disclose information contained in the criminal history record check that is relevant to the disqualification, but may not provide a copy of the criminal history record check to the applicant.</p> <p>(d) Limited Immunity. - A provider and an officer or employee of a provider that, in good faith, complies with this section shall be immune from civil liability for:</p> <p>(1) The failure of the provider to employ an individual on the basis of information provided in the criminal history record check of the individual.</p> <p>(2) Failure to check an employee's history of criminal offenses if the employee's criminal history record check is requested and received in compliance with this section.</p> <p>(e) Relevant Offense. - As used in this section, "relevant offense" means a county, state, or federal criminal history of conviction or pending indictment of a crime, whether a misdemeanor or felony, that bears upon an individual's fitness to have responsibility for the safety and well-being of persons needing mental health, developmental</p> | V 133 | | |

Division of Health Service Regulation

| | | | |
|--|---|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL032-383 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____ | (X3) DATE SURVEY COMPLETED C 09/24/2020 |
|--|---|---|---|

| | |
|---|--|
| NAME OF PROVIDER OR SUPPLIER MELODY HOUSE | STREET ADDRESS, CITY, STATE, ZIP CODE 2727 MARLIN DRIVE DURHAM, NC 27703 |
|---|--|

| (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 133 | <p>Continued From page 5</p> <p>disabilities, or substance abuse services. These crimes include the criminal offenses set forth in any of the following Articles of Chapter 14 of the General Statutes: Article 5, Counterfeiting and Issuing Monetary Substitutes; Article 5A, Endangering Executive and Legislative Officers; Article 6, Homicide; Article 7A, Rape and Other Sex Offenses; Article 8, Assaults; Article 10, Kidnapping and Abduction; Article 13, Malicious Injury or Damage by Use of Explosive or Incendiary Device or Material; Article 14, Burglary and Other Housebreakings; Article 15, Arson and Other Burnings; Article 16, Larceny; Article 17, Robbery; Article 18, Embezzlement; Article 19, False Pretenses and Cheats; Article 19A, Obtaining Property or Services by False or Fraudulent Use of Credit Device or Other Means; Article 19B, Financial Transaction Card Crime Act; Article 20, Frauds; Article 21, Forgery; Article 26, Offenses Against Public Morality and Decency; Article 26A, Adult Establishments; Article 27, Prostitution; Article 28, Perjury; Article 29, Bribery; Article 31, Misconduct in Public Office; Article 35, Offenses Against the Public Peace; Article 36A, Riots and Civil Disorders; Article 39, Protection of Minors; Article 40, Protection of the Family; Article 59, Public Intoxication; and Article 60, Computer-Related Crime. These crimes also include possession or sale of drugs in violation of the North Carolina Controlled Substances Act, Article 5 of Chapter 90 of the General Statutes, and alcohol-related offenses such as sale to underage persons in violation of G.S. 18B-302 or driving while impaired in violation of G.S. 20-138.1 through G.S. 20-138.5.</p> <p>(f) Penalty for Furnishing False Information. - Any applicant for employment who willfully furnishes, supplies, or otherwise gives false information on</p> | V 133 | | |

Division of Health Service Regulation

| | | | |
|--|---|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL032-383 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____ | (X3) DATE SURVEY COMPLETED C 09/24/2020 |
|--|---|---|---|

| | |
|---|--|
| NAME OF PROVIDER OR SUPPLIER MELODY HOUSE | STREET ADDRESS, CITY, STATE, ZIP CODE 2727 MARLIN DRIVE DURHAM, NC 27703 |
|---|--|

| (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 133 | <p>Continued From page 6</p> <p>an employment application that is the basis for a criminal history record check under this section shall be guilty of a Class A1 misdemeanor.</p> <p>(g) Conditional Employment. - A provider may employ an applicant conditionally prior to obtaining the results of a criminal history record check regarding the applicant if both of the following requirements are met:</p> <p>(1) The provider shall not employ an applicant prior to obtaining the applicant's consent for criminal history record check as required in subsection (b) of this section or the completed fingerprint cards as required in G.S. 114-19.10.</p> <p>(2) The provider shall submit the request for a criminal history record check not later than five business days after the individual begins conditional employment. (2000-154, s. 4; 2001-155, s. 1; 2004-124, ss. 10.19D(c), (h); 2005-4, ss. 1, 2, 3, 4, 5(a); 2007-444, s. 3.)</p> <p>This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure the state criminal record check was ordered within five business days of making the conditional offer of employment for one of two audited staff (staff #5). The findings are:</p> <p>Review on 9/24/19 of Staff #5's personnel record revealed: - Hire date: 6/5/19 - Job title: Habilitation Technician - Weekends - The criminal record check was ordered 11/18/19.</p> <p>Interview on 9/24/29 with the Director revealed:</p> | V 133 | | |

Division of Health Service Regulation

| | | | |
|--|---|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL032-383 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____ | (X3) DATE SURVEY COMPLETED C 09/24/2020 |
|--|---|---|---|

| | |
|---|--|
| NAME OF PROVIDER OR SUPPLIER MELODY HOUSE | STREET ADDRESS, CITY, STATE, ZIP CODE 2727 MARLIN DRIVE DURHAM, NC 27703 |
|---|--|

| (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 133 | Continued From page 7 -The FS #6 was responsible for completing staff personnel records and ordering criminal background checks. -Confirmed the criminal background check was not ordered within five days of making the conditional offer. | V 133 | | |
| V 290 | 27G .5602 Supervised Living - Staff 10A NCAC 27G .5602 STAFF (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. (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. (c) Staff shall be present in a facility in the following client-staff ratios when more than one child or adolescent client is present: (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 (2) children or adolescents with developmental disabilities shall be served with one staff present for every one to three clients present and two staff present for every four or | V 290 | | |

Division of Health Service Regulation

| | | | |
|--|---|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL032-383 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____ | (X3) DATE SURVEY COMPLETED C 09/24/2020 |
|--|---|---|---|

| | |
|---|--|
| NAME OF PROVIDER OR SUPPLIER MELODY HOUSE | STREET ADDRESS, CITY, STATE, ZIP CODE 2727 MARLIN DRIVE DURHAM, NC 27703 |
|---|--|

| (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>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 review and interview, the facility failed to assess and document client's capability of having unsupervised time in the home in the treatment affecting three of three audited clients (#1, #2, and #3). The findings are:</p> <p>Review on 9/24/20 of Client # 1's record revealed: -Admission date of 7/31/06. -Diagnosis of Schizoaffective Disorder, Bipolar Type. -Treatment Plan expired 8/20/20. -There was an unsupervised document in the record dated 11/19. -There was no current treatment plan in the client's record. -There was no current treatment plan documenting unsupervised time in the home or community.</p> <p>Review on 9/24/20 of Client # 2's record revealed: -Admission date of 4/30/07.</p> | V 290 | | |

Division of Health Service Regulation

| | | | |
|--|---|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL032-383 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____ | (X3) DATE SURVEY COMPLETED C 09/24/2020 |
|--|---|---|---|

| | |
|---|--|
| NAME OF PROVIDER OR SUPPLIER MELODY HOUSE | STREET ADDRESS, CITY, STATE, ZIP CODE 2727 MARLIN DRIVE DURHAM, NC 27703 |
|---|--|

| (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> <ul style="list-style-type: none"> -Diagnoses of Schizophrenia, Paranoid Type, Major Depressive Disorder and Mild Developmental Disability. -Treatment Plan expired 7/22/20. -There was no current treatment plan in the client's record. -The unsupervised document did not include a date. -There was no current treatment plan documenting unsupervised time in the home or community. <p>Review on 9/24/20 of Client # 3's record revealed:</p> <ul style="list-style-type: none"> -Admission date of 7/2/19. -Diagnoses of Schizoaffective Disorder, Bipolar Type. -Treatment Plan dated 10/29/19. -The unsupervised document did not include a date. -The treatment plan did not document unsupervised time in the home or community. <p>Interview on 9/24/20 with Client #1 revealed:</p> <ul style="list-style-type: none"> -He reported staff #4 worked at the facility. -The girl across the street prepared breakfast, lunch and dinner and administered medication. -Staff at the other house worked at both homes at the same time. -They were left alone sometimes. -"If I had a problem I would just go across the street." -Staff #5 worked at the facility on the weekends. -There was always staff at night and overnight. -Staff #4 worked at night. -Between the hours of 8 a.m. and 7 p.m. staff across the street would come and check on us. -He was allowed unsupervised time in the home and community. <p>Interview on 9/24/20 with Client #2 revealed:</p> | V 290 | | |

Division of Health Service Regulation

| | | | |
|--|---|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL032-383 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____ | (X3) DATE SURVEY COMPLETED C 09/24/2020 |
|--|---|---|---|

| | |
|---|--|
| NAME OF PROVIDER OR SUPPLIER MELODY HOUSE | STREET ADDRESS, CITY, STATE, ZIP CODE 2727 MARLIN DRIVE DURHAM, NC 27703 |
|---|--|

| (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> <ul style="list-style-type: none"> -He was allowed unsupervised time in the community. -Client did not provide additional information. <p>Interview on 9/24/20 with Client #3 revealed:</p> <ul style="list-style-type: none"> -He was allowed unsupervised time in the home and community. -Staff #4 was always at the home. -Staff across the street would come to administer medication. -Staff across the street prepared meals. -Staff #5 worked on the weekend at both homes. -The Director would come to the house about 3-4 times a week. <p>Interview on 9/24/20 with Staff #1 revealed:</p> <ul style="list-style-type: none"> -He worked 7 p.m. to 8 a.m. -He reported other staff worked at the facility. -Confirmed staff at the sister facility prepared meals and administered medication to clients. -He did not administer medication. -He was responsible for supervising clients. -Reported he completed all trainings as a Habilitation Technician. <p>Interview on 9/24/20 with Former Staff #6 revealed:</p> <ul style="list-style-type: none"> -She was the program coordinator for the home. -Resigned in August 2020. -Staff at the other home had to work at both homes. -Staff at the other home was responsible for medication administration and preparing meals for both homes. -Staff at the other home periodically worked rounds for both homes. -Staff at the other home was supposed to inform the Director when relief staff did not show up for both homes. -Staff #4 was there and sometimes staff #4 was | V 290 | | |

Division of Health Service Regulation

| | | | |
|--|---|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL032-383 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____ | (X3) DATE SURVEY COMPLETED C 09/24/2020 |
|--|---|---|---|

| | |
|---|--|
| NAME OF PROVIDER OR SUPPLIER MELODY HOUSE | STREET ADDRESS, CITY, STATE, ZIP CODE 2727 MARLIN DRIVE DURHAM, NC 27703 |
|---|--|

| (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> <p>not.</p> <ul style="list-style-type: none"> -Staff #4 attended all trainings; he was still staff. -For the most part staff #4 was there. -Staff #4 attended every class and in-service. -Clients was allowed unsupervised time in the home and community. <p>Interview on 9/24/20 with the Director revealed:</p> <ul style="list-style-type: none"> -Clients were allowed unsupervised time in the house and community. -She did not want clients going to certain places or be home by themselves. -Confirmed the unsupervised time documentation did not include restrictions in the community or home. -Confirmed the unsupervised did not include date signed for client #2 and client #3. -Confirmed staff at the sister facility administered medications and prepared meals for clients at this home. -Staff #5 worked 2:00 p.m. and 9 a.m. on the weekends. -Staff #4 worked all the time. -There should not be gaps in staff supervision. | V 290 | | |