Division of Health Service Regulation

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
74101 2741	or dorace mon	IDEITH IOTHORNOLLI	A. BUILDING: _	A. BUILDING:		
		MHL032-498	B. WING		C 10/02/2020	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
MELODY	HOUSE#1, LLC		ARWOOD DRIV	E		
			, NC 27707			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLET	TE
V 000	INITIAL COMMENTS		V 000			
		as completed on October 2, was substantiated (intake ciencies cited.				
	category: 10A NCAC	d for the following service 27G. 5600C Adults with Developmental				
V 108	27G .0202 (F-I) Perso	onnel Requirements	V 108			
	(g) Employee training provided and, at a min following: (1) general organiza (2) training on client delineated in 10A NC 10A NCAC 26B; (3) training to meet to client as specified in the plan; and (4) training in infection bloodborne pathogen (h) Except as permitted. 5602(b) of this Subchmember shall be avait times when a client is member shall be trainincluding seizure mar to provide cardiopulm trained in the Heimlich techniques such as the the American Heart A equivalence for reliev (i) The governing box	cion shall be documented. It is programs shall be nimum, shall consist of the stional orientation; rights and confidentiality as AC 27C, 27D, 27E, 27F and the mh/dd/sa needs of the he treatment/habilitation to bus diseases and seed under 10a NCAC 27G napter, at least one staff lable in the facility at all present. That staff leed in basic first aid lagement, currently trained onary resuscitation and in maneuver or other first aid lose provided by Red Cross, ssociation or their ling airway obstruction.				

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

TITLE (X6) DATE

Division of Health Service Regulation

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		7. BOILDING.		С		
		MHL032-498 B. WING		10/02/202	20	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
MELODY	HOUSE#4 11.0	3116 CED	ARWOOD DRIV	E		
MELODY	HOUSE#1, LLC	DURHAM,	NC 27707			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COM	(X5) MPLETE DATE
V 108	Continued From page	2 1	V 108			
		g and controlling infectious seases of personnel and				
	failed to ensure two of #4) received training needs of the clients a	ew and interviews the facility f three audited staff (#3 and to meet the MH/DD/SA				
	Review on 10/2/20 of Staff #3 personnel record revealed: -Hired date: 8/5/20Employed as a Habilitation TechnicianWorked 9 a.m 2 p.m. Monday - ThursdayThere was no evidence of mental health/developmental disability/substance abuse training in the record.					
	revealed: -Hired date: 8/5/20Employed as a Habil -Worked 2 p.m - 9 p.r -There was no evider	n. Monday - Thursday. nce of mental disability/substance abuse				
	Program Coordinator -Confirmed staff #3 di working with special p	id not receive training				

training.

Division of Health Service Regulation

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Division of Health Service Regulation

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SI COMPLE	
		MHL032-498 B. WING			10/0	; 2/2020
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
MELODY	HOUSE#1, LLC		ARWOOD DRIV , NC 27707	E		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
V 108	have trained new staf	eualified Professional should f. as considered in house staff	V 108			
V 112	PLAN (c) The plan shall be assessment, and in p legally responsible per of admission for client receive services beyond (d) The plan shall incompose the projected date of achieved by provision projected date of achieved (2) strategies; (3) staff responsible; (4) a schedule for reannually in consultation responsible person of (5) basis for evaluation outcome achievement (6) written consent of responsible party, or a session of the plant shall be added to the plant shall be added to the plant shall be asserted to the pla	developed based on the artnership with the client or erson or both, within 30 days ts who are expected to and 30 days. clude: I that are anticipated to be a of the service and a evement; view of the plan at least on with the client or legally both; on or assessment of	V 112			

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Division of Health Service Regulation

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL032-498	B. WING		10/0	2/2020
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
MELODY	HOUSE#1, LLC	3116 CEDA DURHAM, I	RWOOD DRIV	E		
()(1)	SLIMMADV ST	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTION		(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
V 112	Continued From page	÷ 3	V 112			
	facility failed to have a one of two audited cli Review on 9/30/20 of -Admission date of 5/-Diagnoses of Schizo Type and Mild Intelled -Treatment Plan expire	ews and interview, the a current treatment plan for ents (#2). The findings are: Client # 2's record revealed: 12/10. affective Disorder, Bipolar ctual Disability.				
	Interview on 10/2/20 with the Director and Acting Program Coordinator revealed: -The day program was responsible for completing treatment plans. -Confirmed treatment plans expired for client #2. -The day program said client #2's treatment plan was current for billing. -She would make sure client #2 had a current treatment plan in the record.					
V 131	G.S. 131E-256 (D2) F Verification	HCPR - Prior Employment	V 131			
	REGISTRY (d2) Before hiring hea health care facility or health care facility sh	ALTH CARE PERSONNEL Alth care personnel into a service, every employer at a all access the Health Care and shall note each incident opriate business files.				

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Division of Health Service Regulation

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
,	5. GG.W.EG.WG.	1521111110711101111011152111	A. BUILDING: _		
		MHL032-498	B. WING		C 10/02/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
MELODY	HOUSE#1, LLC		RWOOD DRIV	Æ	
	QUILLEN OT	DURHAM,			
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
V 131	Continued From page	e 4	V 131		
V 133	This Rule is not met Based on record revie failed to access the H Registry (HCPR) prio three audited staff (#8 Review on 10/2/20 of revealed: -Hired date: 7/5/19Employed as Habilita-The HCPR was accellated in the HCPR was accellated in the HCPR was not in the previous program responsible for personable	as evidenced by: ew and interview the facility lealth Care Personnel r to employment for one of 5). The findings are: staff #5 personnel record ation Technician. essed on 9/30/20. with the Director revealed: HCPR was assessed prior the personnel record. m coordinator was nnel files. by the document was not in al History Record Check IINAL HISTORY RECORD FOR CERTAIN EMPLOYMENT. ed in this section, the term an area authority/county vider of mental health, lity, and substance abuse able under Article 2 of this in offer of employment by a	V 133		

Division of Health Service Regulation

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Division of Health Service Regul	lation		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:	(X3) DATE SURVEY COMPLETED
	MHL032-498	B. WING	C 10/02/2020
NAME OF PROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STATE, ZIP CODE	
MELODY HOUSE#1, LLC	3116 CEDA DURHAM, N	RWOOD DRIVE NC 27707	

D D		DURHAM, NC 27707		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FUL REGULATORY OR LSC IDENTIFYING INFORMATION	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
PRÉFIX	Continued From page 5 the applicant has been a resident of this State less than five years, then the offer of employn is conditioned on consent to a State and natio criminal history record check of the applicant. national criminal history record check shall include a check of the applicant's fingerprints. the applicant has been a resident of this State five years or more, then the offer is conditione on consent to a State criminal history record check of the applicant. A provider shall not employ an applicant who refuses to consent to 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 provide 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. Notwithstandin G.S. 114-19.10, the Department of Justice shall results of national criminal history record checks for employment positions not covered by Public Law 105-277 to the Department of Health and Human Services, Criminal Records Check Unit. Within five business days of receipt of the national crimin 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 employable.	L PREFIX TAG V 133 e for ment onal The If e for ed o a ng er rd ng all the kkee illity	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETE
	of the applicant. In no case shall the results of national criminal history record check be shard with the provider. Providers shall make availal 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	ed ble y ed		

Division of Health Service Regulation

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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:	
				С
	MHL032-498	B. WING		10/02/2020
NAME OF PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE	
MELODY HOUSE#4 LLC	3116 CEI	DARWOOD DRIV	E	
MELODY HOUSE#1, LLC	DURHAN	I, NC 27707		
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
V 133 Continued From page	e 6	V 133		
the Division of Crimin may conduct on beha criminal history reconsection without the prequest to the Depart case, the county shall criminal history reconsection within five bus conditional offer of er All criminal history information provider is confidential except to the application (c) of this section. For subsection, the term business regularly encriminal history reconsected obtained from (c) Action If an apprecord check reveals a relevant offense, the of the following factor hire the applicant: (1) The level and series (2) The date of the criminal history reconsistion. (4) The circumstance commission of the criminal history reconsection. (5) The nexus between the person and the join filled. (6) The prison, jail, prehabilitation, and emperson since the date (7) The subsequent of a relevant offense. The fact of convictions.	al 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 inployment by the provider. formation received by the al and may not be disclosed, in as provided in subsection in purposes of this "private entity" means a gaged in conducting d checks utilizing public in a State agency. Ilicant's criminal history one or more convictions of e provider shall consider all is in determining whether to ousness of the crime. ime. rson at the time of the s surrounding the me, if known. en the criminal conduct of b duties of the position to be	V 133		

Division of Health Service Regulation

STATE FORM 6899 F79811 If continuation sheet 7 of 13

Division of Health Service Regulation

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION	(X3) DATE S	
74101 1541	or correction.	IBERTINIO/RITOR ROMBER.	A. BUILDING: _		0011111	-125
						;
		MHL032-498	B. WING		10/0	2/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE		
		3116 CEI	ARWOOD DRIV	Æ		
MELODY	HOUSE#1, LLC	DURHAM	, NC 27707			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
V 133	Continued From page	e 7	V 133			
V 133	If the provider disqual consideration of the reprovider may disclose the criminal history reto the disqualification of the criminal history applicant. (d) Limited Immunity. or employee of a provice complies with this sectivity or employee of a provice complies with this sectivity or employee of the provice of the provi	lifies an applicant after elevant factors, then the enformation contained in cord check that is relevant, but may not provide a copy record check to the - A provider and an officer wider that, in good faith, cition shall be immune from corovider to employ an sof information provided in cord check of the individual. In employee's history of employee's criminal sometion. - As used in this section, cans a county, state, or end of conviction or pending whether a misdemeanor or on an individual's fitness to the safety and well-being of that health, developmental check of Chapter 14 of the collection of	V 133			
	and Other Housebrea Other Burnings; Articl	ikings; Article 15, Arson and e 16, Larceny; Article 17, Embezzlement; Article 19,				

Division of Health Service Regulation

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Division of Health Service Regulation

DIVISION	of Health Service Regu	liation			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	1 ' '	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	ECTION IDENTIFICATION NUMBER: A. BUILDIN			COMPLETED
					С
		MHL032-498	B. WING		10/02/2020
		III1E032-430			10/02/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE	
		3116 CE	DARWOOD DRIV	Æ	
MELODY	HOUSE#1, LLC	DURHAN	I, NC 27707		
(V4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID.	PROVIDER'S PLAN OF CORRECTION	N (X5)
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD	
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROP	RIATE DATE
				DEFICIENCY)	
V 133	Continued From page	e 8	V 133		
	Falsa Bustanasa and	Ob t A-t t - 40A			
	False Pretenses and				
		Services by False or			
		edit Device or Other Means;			
	·	Transaction Card Crime			
		s; Article 21, Forgery; Article			
	26, Offenses Against	-			
		, Adult Establishments;			
	•	n; Article 28, Perjury; Article			
	•	I, Misconduct in Public			
		enses Against the Public			
		Riots and Civil Disorders;			
	Article 39, Protection				
	Protection of the Fam	cle 60, Computer-Related			
		also include possession or			
		ion of the North Carolina			
		es Act, Article 5 of Chapter			
		atutes, and alcohol-related			
		e to underage persons in			
	violation of G.S. 18B-	- -			
		of G.S. 20-138.1 through			
	G.S. 20-138.5.	51 G.G. 20 100.1 amough			
		ning False Information Any			
		nent who willfully furnishes,			
		e gives false information on			
	an employment appli	cation that is the basis for a			
		d check under this section			
		ass A1 misdemeanor.			
	(g) Conditional Emplo	oyment A provider may			
	employ an applicant of				
		of a criminal history record			
		applicant if both of the			
	following requirement	ts are met:			
	(1) The provider shall	l not employ an applicant			
	prior to obtaining the	applicant's consent for			
	criminal history record	d check as required in			
	subsection (b) of this	section or the completed			
	fingerprint cards as re	equired in G.S. 114-19.10.			
	(2) The provider shall	submit the request for a			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
,	5. GG. W.EG. 1611	152.1111.107.11101.1110.1152.11	A. BUILDING: _		
		MHL032-498	B. WING		C 10/02/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE	
MELODY	HOUSE#1, LLC		DARWOOD DRIV I, NC 27707	Æ	
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT	TION (X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE COMPLETE
V 133	Continued From page	9	V 133		
	criminal history record business days after the conditional employme 2001-155, s. 1; 2004-	d check not later than five ne individual begins			
	failed to ensure the st was ordered within five the conditional offer of three audited staff (#4222) off revealed: -Hired date: 8/5/20. -Employed as a Habil	ew and interview, the facility tate criminal record check we business days of making of employment for two of 4 and #5). The findings are: Staff #4 personnel record			
	revealed: -Hired date: 7/5/19. -Employed as Habilita	Staff #5 personnel record ation Technician.			
	Program Coordinator -Staff #4's and staff # was ordered prior to h careConfirmed the staff # record check was not	5's criminal record check nired and providing direct 4's and staff #5's criminal			

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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
7.1.2.2.1.1		.52	A. BUILDING: _	A. BUILDING:		
						С
		MHL032-498	B. WING		10	/02/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
		3116 CE	DARWOOD DRIV	Æ		
MELODY	HOUSE#1, LLC	DURHAN	M, NC 27707			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C	ORRECTION	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	E APPROPRIATE	COMPLETE DATE
V 133	Continued From page	e 10	V 133			
	system.					
	-They were not able t	o retrieve the report				
V 290	27G .5602 Supervise	d Living - Staff	V 290			
	10A NCAC 27G .5602	2 STAFF				
	(a) Staff-client ratios					
	` '	Paragraphs (b), (c) and (d)				
		letermined by the facility to				
		nd to individualized client				
	needs.					
	(b) A minimum of one	e staff member shall be				
	present at all times w	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				
		s than annually to ensure be be capable of remaining in				
		ity without supervision for				
	specified periods of ti	*				
	(c) Staff shall be pres					
		atios when more than one				
	child or adolescent cli					
	()	adolescents with substance				
		be served with a minimum				
		or every five or fewer minor				
		vever, only one staff need be				
		ng hours if specified by the				
	the governing body; of	procedures determined by				
		adolescents with				
	\ <i>\</i>	lities shall be served with				
	•	every one to three clients				
		present for every four or				
		However, only one staff				
	need be present durir					
		gency back-up procedures				
	determined by the go	verning body.				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			С	
MHL0:		MHL032-498	B. WING		l l	10/02/2020	
NAME OF P	ROVIDER OR SUPPLIER	TE, ZIP CODE					
MELODY	HOUSE#1, LLC		ARWOOD DRIV	Œ			
	·		I, NC 27707				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE AI CROSS-REFERENCED TO DEFICIEI	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETE DATE	
V 290	Continued From page 11		V 290				
	diagnosis is substance (1) at least one duty shall be trained i withdrawal symptoms secondary complication drug addiction; and	ons to alcohol and other s of a certified substance ll be available on an					
	failed to assess and of having unsupervise the treatment plan aff clients (#2). The find Review on 9/30/20 of -Admission date of 5/-Diagnoses of Schizo Type and Mild Intellector -Treatment Plan expiration -There was an unsupercord with no date.	ew and interview, the facility document client's capability ed time in the community in fecting one of two audited ings are: Client #2's record revealed: 12/10. affective Disorder, Bipolar ctual Disability. red 8/23/19. ervised document in the ten revisions made with no at treatment plan					
	-When she went out,						

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED						
				С							
MHL032-498			B. WING		10/02/2020	10/02/2020					
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STA								
MELODY HOUSE#1, LLC DURHAM, NC 27707											
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLE	ETE					
V 290	-She spent most of the walking around the hold interview on 10/2/20 or Program Coordinator -Confirmed client #2 hrough -Confirmed the unsup no dateConfirmed there was	ne day cleaning up and buse since the pandemic. with the Director and Acting revealed: nad unsupervised.	V 290								

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