Division of Health Service Regulation

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NOWIBER.	A. BUILDING:		COMPLETED	
		MHL034-303	B. WING		03/10/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
CHADDE	AND WILLIAMS #2	4408 NOR	THAMPTON DE	RIVE		
SHARPE	AND WILLIAMS #2	WINSTON	-SALEM, NC 2	7105		
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE	
V 000	INITIAL COMMENTS	;	V 000			
	A complaint and follow up survey was completed on March 10, 2021. The complaint (Intake #NC00175063) was unsubstantiated. Deficiencies were cited. This facility is licensed for the following service categroy:10A NCAC 27 .5600A Supervised Living for Adults with Mental Illness.					
V 118	27G .0209 (C) Medic	ation Requirements	V 118			
	10A NCAC 27G .0209 MEDICATION REQUIREMENTS (c) Medication administration: (1) Prescription or non-prescription drugs shall only be administered to a client on the written order of a person authorized by law to prescribe drugs. (2) Medications shall be self-administered by clients only when authorized in writing by the client's physician. (3) Medications, including injections, shall be administered only by licensed persons, or by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer medications. (4) A Medication Administration Record (MAR) of all drugs administered to each client must be kept current. Medications administered shall be					
	recorded immediately MAR is to include the (A) client's name; (B) name, strength, a (C) instructions for ac (D) date and time the (E) name or initials of drug. (5) Client requests for	/ after administration. The following: nd quantity of the drug;				

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

(X6) DATE TITLE

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL034-303	B. WING		03/10/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STAT	E, ZIP CODE		
SHARPE	AND WILLIAMS #2		RTHAMPTON DR N-SALEM, NC 27			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
V 118		oointment or consultation	V 118			
	This Rule is not met a Based on observation interviews, the facility written physician's ord self-medicate. The fin	s, record reviews and staff failed to obtain a der for 1 of 3 clients to				
	drawer night stand -The Tylenol was 500	bedroom revealed: visible in his clear three				
	-An admission date of -Diagnoses of Schizo (Chronic Obstructive Hypothyroidism, Vitar Hyperlipidemia, Chron Arthritis, Pre-Diabetes Failure -An assessment date continued to express to his family and residemore means of social communication with of Psychiatric Residential previously, his health	affective Disorder, COPD Pulmonary Disease, nin D Deficiency, nic Back Pain, Insomnia, s, Scoliosis, and Respiratory d 10/1/20 noting "has his desire of moving closer ling in a facility that provides				

Division of Health Service Regulation

STATE FORM 6899 HN5O11 If continuation sheet 2 of 7

Division of Health Service Regulation

Division of Health Service Regulation							
		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED		
MIII 004 000		B. WING		00/40/0004			
		MHL034-303	B: ********		03/10/2021		
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE			
		4408 NOF	THAMPTON DE	RIVE			
SHARPE	AND WILLIAMS #2		-SALEM, NC 2				
	OLIMANA DV OT		· ·			—	
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	(-1-)	re l	
PREFIX TAG	•	SC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPR		-	
				DEFICIENCY)			
1/ 440	0 " 15		1/ 440			\neg	
V 118	Continued From page	2	V 118				
	assistance with ensur	ina his hvaiene is					
		sistance with housework,					
	•	ation, money management,					
	shopping and transpo	, ,					
	communicating thoug						
		tive associations and has a					
	history of inappropriat						
	*	ed 10/1/20 noting "will					
	•	feeling in a coherent and					
		emonstrate reality-based					
	_	rbal communication, will					
		or two other people in a					
	structured activity, wil						
	•	at work to decrease anxiety					
	• •	lity to think clearly and					
		will attend one structured ek out supportive social					
		e social interactions, use					
	appropriate social ski	on with another client while					
		demonstrate interest to start appropriate skills to initiate					
		on, will learn ways to refrain					
		allucinations, will state three					
		tress levels are high, will					
	, ,	om 1 to 10 that the voices					
	_	uent and threatening, will					
		·					
	identify two stressful enhaltucinations, will de						
		will demonstrate techniques					
	that help distract him						
	_	of delusional thoughts if they					
		ate satisfying relationships					
		develop trust in at least one				ļ	
	staff member, will sus					ļ	
		plete tasks or activities, will				ļ	
		ctive coping skills that					
	minimize delusional th	noughts, will avoid high-risk					

Division of Health Service Regulation

environments, will respond to the medication within the therapeutic levels, will take short

STATE FORM 6899 HN5O11 If continuation sheet 3 of 7

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA				(3) DATE SURVEY COMPLETED	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED	
		MHL034-303	B. WING		03/	10/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE			
SHARDE	AND WILLIAMS #2	4408 NOF	RTHAMPTON DE	RIVE			
SHARFE	AND WILLIAMS #2	WINSTON	N-SALEM, NC 2	7105			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE / CROSS-REFERENCED [*] DEFICI	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETE DATE	
V 118	Continued From page	3	V 118				
	verbal threats and lou towards others, will dehaviors, will identify possible need for intermember's mood escal hours every night, will at least one snack be least every other day dress and groom self will refrain from atterm safe while in the facility reduction of self-destrecognize frequent some problem and decide to correct them, will a	s feeling, will refrain from ad, profane language ecrease manipulative three signs that indicate revention with their family lates, will sleep at least 6 I eat half of each meal plus tween meals, will bathe at while in the facility, will in an appropriate manner, upting suicide and will remain ty, will demonstrate a ructive behaviors, will noking of cigarettes as a on appropriate health actions ccess the community at eek, will gain control over his					
	revealed: -Physician's orders, of the following: -Artane 2mg ½, one to Famotidine 20mg, or Trazodone 100mg, or Citalopram 20mg, or Levothyroxine 50mg Lipitor 20mg, one by Zyprexa 15mg, two to Trazodone 50mg, or Roflumilast 500mg, or Vitamin D3, 1000mg Aspirin 81mg, one by Baclofen 10mg, one Albuterol 108mcg infineeded	ne by mouth twice daily the by mouth every night the by mouth every day to one by mouth every day mouth every day by mouth twice daily the by mouth every night one by mouth every day to one by mouth every day to one by mouth every day to mouth every day mouth every day					

Division of Health Service Regulation

STATE FORM 6899 HN5O11 If continuation sheet 4 of 7

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SI COMPLE	
			A. BOILDING.			
MHL034-303		B. WING		03/1	0/2021	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
SHARPE A	AND WILLIAMS #2		THAMPTON DE SALEM, NC 2			
(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 SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
V 118	-When asked about the client #1 stated "I do not client #1 stated "I do noom. I keep it in my of for me. I had one last -Stated he did not tell Tylenol in his roomDid not think the door for the Tylenol"One time the doctor since I have moved he gave it to me after I he facility) for one month. Interview on 3/9/21 we to remain anonymous -Approximately 2 weehad 2 Tylenol pills in a -Was concerned becate to take his own medic -"He could have taken taken more. The med locked up" Interview on 3/9/21 we -Stated client #1 liked -Was not aware client Tylenol bottle in his din." -His family was not his Interview on 3/10/21 we Guardian revealed:	for Tylenol allowing client #1 to ith client #1 revealed: ne Tylenol in his bedroom, have some Tylenol in my drawer. [My sister] brought it night and one yesterday." the facility staff he had the tor gave him a prescription said I could take it but not ere (10/1/20). [My sister] ad been living here (at the n." ith a person whom wanted s revealed: eks ago, a client at the facility their room ause that client was not able cations. In them, turned around and lications are supposed to be ith staff #1 revealed: I to hoard things in his room. It #1 had an over the counter resser. I to hoard things in his room. It #1 had an over the counter resser. I to hoard things in his room. It #1 had an over the counter I to hoard things in his room. It #1 had an over the counter I to hoard things in his room. It #1 had an over the counter I to hoard things in his room. It #1 had an over the counter I to hoard things in his room. It #1 had an over the counter I to hoard things in his room. It #1 had an over the counter I to hoard things in his room. It #1 had an over the counter I to hoard things in his room. It #1 had an over the counter I to hoard things in his room. It #1 had an over the counter I to hoard things in his room. It #1 had an over the counter I to hoard things in his room. It #1 had an over the counter I to hoard things in his room. It #1 had an over the counter I to hoard things in his room. It #1 had an over the counter I to hoard things in his room. It #1 had an over the counter I to hoard things in his room. It #1 had an over the counter I to hoard things in his room. I to hoard	V 118	DEL NOILNO I)		
	-Was made aware this week that one of client #1 had a Tylenol bottle in his room.					

Division of Health Service Regulation

STATE FORM 6899 HN5O11 If continuation sheet 5 of 7

Division of Health Service Regulation

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL034-303	B. WING		03/1	0/2021
NAME OF PE	ROVIDER OR SUPPLIER		RESS, CITY, STA		03/1	0/2021
			HAMPTON DF			
SHARPE A	AND WILLIAMS #2	WINSTON-	SALEM, NC 2	7105		
(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 I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
V 118	Continued From page	5	V 118			
	Continued From page 5 -Client #1 was unable to self-medicate"That has to stop. It could damage his liver." Interview on 3/9/21 with staff #3 revealed: -Moved into his role of Medication Technician 3 months agoWas not aware client #1 had over the counter Tylenol in his room -Would get with the QP to determine what the next step would be and how to dispose of the Tylenol or obtain a physician's order. Interview on 3/9/21 with the Qualified Professional (QP) revealed: -Was not aware client #1 had a bottle of Tylenol in his room -It was concerning that no one knew how he obtained it"If [client #1]'s wants Tylenol, I will ask his physician to write an order for it." -Clients' medications were to be locked up.					
V 131	Verification G.S. §131E-256 HEAREGISTRY (d2) Before hiring health care facility or health care facility sha	HCPR - Prior Employment LTH 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.	V 131			

Division of Health Service Regulation

STATE FORM 6899 HN5O11 If continuation sheet 6 of 7

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CO			E SURVEY PLETED	
		MHL034-303	B. WING		03	3/10/2021
	ROVIDER OR SUPPLIER AND WILLIAMS #2	4408 NC	NDDRESS, CITY, STATE PRTHAMPTON DRIV DN-SALEM, NC 271	/ E		
(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 DEFICIENCE	FION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
V 131	This Rule is not met Based on record revir facility failed to comp Personnel Record (H 2 of 3 (#1 and #3) state Review on 3/10/21 of -A hire date of 3/2/21 -A job description of proceeding -A HCPR check compression of proceeding -A hire date of 4/2/19 -A job description of proceeding -A HCPR check compressional (QP) review on 3/10/21 of -A hire date of 4/2/19 -A job description of proceeding -A HCPR check compressional (QP) review on 3/10/21 of -A hire date of 4/2/19 -A job description of proceeding -A HCPR check compressional (QP) review on 3/10/21 of -A hire date of 4/2/19 -A job description of proceeding -A hire date of 4/2/19 -A job d	as evidenced by: ews and interviews, the lete a Health Care CPR) check prior to hire for aff. The findings are: If staff #1's record revealed: Daraprofessional Deted on 3/9/21 If staff #3's record revealed: Daraprofessional Deted on 4/2/19 With the Qualified Deted on 4/2/19 With the Human Resource Description and in the future, I Detecks are done prior to	V 131			

Division of Health Service Regulation

STATE FORM 6899 HN5O11 If continuation sheet 7 of 7