

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  MHL034-309	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 03/12/2021
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  INDEPENDENT LIVING AT RANSOM RD	STREET ADDRESS, CITY, STATE, ZIP CODE 355 RANSOM ROAD WINSTON SALEM, NC 27106
---	---

(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	INITIAL COMMENTS  INITIAL COMMENTS A complaint survey was completed on 3/12/21. The complaint was substantiated (intake #NC00175127). Deficiencies were cited.  This facility is licensed for the following service category: 10A NCAC 27G .5600B Supervised Living for Minors with Developmental Disability.  The facilities identified as facility A are owned by Licensee #2. Staff and/or clients will be identified using the letter of the facility and a numerical identifier.	V 000		
V 112	27G .0205 (C-D) Assessment/Treatment/Habilitation Plan  10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (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. (d) The plan shall include: (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	V 112	DHSR - Mental Health  APR 19 2021  Lic. & Cert. Section	

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

*Ashanta Powell*

*Wheeler*

TITLE

4/5/21 (X6) DATE

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL034-309</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>03/12/2021</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>INDEPENDENT LIVING AT RANSOM RD</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>355 RANSOM ROAD</b> <b>WINSTON SALEM, NC 27106</b>
--	---

(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>obtained.</p> <p>This Rule is not met as evidenced by: Based on record review, observations and interviews the facility failed to implement strategies for 3 of 3 clients (#1, #2 and #3). The findings are:</p> <p>Review on 2/15/21 of client #1's record revealed: - Admission Date: 12/2017 - Diagnoses: Autism; Post Traumatic Stress Disorder (PTSD); Attention Deficit Hyperactivity Disorder (ADHD); and Moderate Intellectual and Developmental Disabilities (IDD) - Age: 17</p> <p>Review on 2/15/21 of client #2's record revealed: - Admission Date: 9/22/17 - Diagnoses: Autism; ADHD; Reactive Attachment Disorder; and Impulse Control Disorder; Suicidal Ideation; Bipolar Disorder; Disruptive Mood Dysregulation Disorder; and Pervasive Developmental Disorder Not Otherwise Specified (NOS) - Age: 17 - Review of Client #2's PCP (Person Centered Profile) dated 6/1/20 revealed: "needs 1:1 residential support, day supports individual when not in school, Specialized Consulting Services to maintain and update his behavior plan."</p> <p>Review on 2/3/21 of client #3's record revealed:</p>	V 112	<p>The agency will implement strategies for all the people we serve. The agency will utilize strategies from the ISP and the BSP (if applicable) to meet those. This will happen by way of additional staff training if needed. This will be done by the QP and will be ongoing.</p>	4/5/21

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL034-309</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>03/12/2021</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>INDEPENDENT LIVING AT RANSOM RD</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>355 RANSOM ROAD</b> <b>WINSTON SALEM, NC 27106</b>
--	---

(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 2</p> <ul style="list-style-type: none"> <li>- Admission Date:10/5/18</li> <li>- Diagnoses: Autism</li> <li>- Age: 14</li> <li>- Review of Client #3's PCP dated 8/1/19 revealed: "... requires 24/7 supervision and consistent care due to his autism spectrum disorder...While in the community [client #3] must be within arm's reach to also ensure that he does not wander off and he can be easily exploited."</li> </ul> <p>Observations at the 5400 Day Program owned by the provider (Sister facility A) and interviews on 2/12/21 and 2/19/20 at 11:22 am with staff A2 revealed:</p> <ul style="list-style-type: none"> <li>- On 2/12/21 at approximately 11:22 am observed Day Program clients in a large room and 6 individuals in a back room sitting at tables with computers.</li> <li>- Clients #1, #2, and #3 were 3 of the 6 clients in the back room doing "virtual learning."</li> <li>- Virtual learning took place Monday-Friday 8:30 am- 2:30 pm, in the same building as the 5400 program (Day Activity - All Disabilities).</li> <li>- Staff A2 was the only staff who worked there each day from 8:30 am-2:30 pm. He drove the van, monitored the clients in virtual learning, and helped the clients with their schoolwork.</li> <li>- He only worked for the Day Program and not for the Independent Living at Ransom Road group home therefore was not familiar with the client's residential treatment needs/goals.</li> <li>- The clients were in the 5400 program (Day Activity-All Disabilities) Monday-Friday from 8:30 am- 2:30 pm because the group home only provided staff on 2nd and 3rd shift.</li> </ul> <p>Interview on 2/12/21 with client #1 revealed:</p> <ul style="list-style-type: none"> <li>- He was 17 years old and normally attended school at a local high school.</li> <li>- He had been doing virtual learning at the 5400</li> </ul>	V 112		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL034-309</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>03/12/2021</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>INDEPENDENT LIVING AT RANSOM RD</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>355 RANSOM ROAD</b> <b>WINSTON SALEM, NC 27106</b>
--	---

(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 3</p> <p>program (Day Activity - All Disabilities) since the beginning of the school year.</p> <ul style="list-style-type: none"> <li>- He did virtual learning at the day program Monday-Friday from 8:30 am-2:30 pm.</li> <li>- While in virtual learning there was one staff in the room with 6 students.</li> </ul> <p>Interview on 2/12/21 with client #2 revealed:</p> <ul style="list-style-type: none"> <li>- He was 17 years old and normally attended school at a local high school.</li> <li>- He had been doing virtual learning at the 5400 program (Day Activity - All Disabilities) since COVID-19 started last year. He attended virtual learning Monday-Friday from 8:30 am to 2:30 pm.</li> <li>- Normally there was only one staff present in the virtual learning program.</li> </ul> <p>Attempted interview on 2/12/21 with client #3 revealed:</p> <ul style="list-style-type: none"> <li>- Client #3 was unable to respond to any questions.</li> </ul> <p>Review on 2/3/21, 2/15/21-2/17/21 of 11 client records from the 5400 Day Program (Facility A) revealed:</p> <ul style="list-style-type: none"> <li>- Five clients had a history of inappropriate sexual behavior. Some of their histories included, "...exposing self in public, inappropriate gesturing and touching of children, aberrant sexual behavior including peeping and exposing himself in public areas, sexual aggression which includes oral sex with a child."</li> <li>- Nine clients had a history of serious aggressive and violent behavior.</li> <li>- Many required one-on-one supervision.</li> <li>- No admission assessments or day treatment goals for client #1, #2 nor #3.</li> </ul> <p>Interviews on 2/10/21 and 2/11/21 with client #1 revealed:</p>	V 112		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  MHL034-309	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 03/12/2021
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  INDEPENDENT LIVING AT RANSOM RD	STREET ADDRESS, CITY, STATE, ZIP CODE 355 RANSOM ROAD WINSTON SALEM, NC 27106
---	---

(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 4</p> <ul style="list-style-type: none"> <li>- He rode the van to and from the day program with the adult clients.</li> <li>- On 1/22/21, there was an altercation with him and former client (FC) A6 (who was an adult). The altercation was instigated by FC A6 when he tried to bite client #1. Client #1 scratched FC A6's face and neck in defense.</li> <li>- "[FC A6] was destroying the van. I got upset. [FC A6] tried to break the window too. Then [FC A6] went to sleep and we arrived at the group home."</li> </ul> <p>Interviews on 2/9/21 and 2/11/21 with the Van Driver revealed:</p> <ul style="list-style-type: none"> <li>- On 1/22/21 FC A6 did not want to get on the van at the day program to go back to the group home because he thought he was going home with his sister.</li> <li>- FC A6 had extreme behaviors on the van on 1/22/21. FC A6 took his clothes off and defecated in the van seat. He became violent and hit the van.</li> <li>- While driving the van on 1/22/21 he heard someone say FC A6 had attacked client #1 and client #3. He told FC A6 to calm down. Client #1 and FC A6 were sitting on the same row in the very back of the van (4th row) and client #3 was sitting in front of FC A6 on the van.</li> <li>- Due to FC A6's behaviors on the van he dropped FC A6 off first.</li> <li>- He drove 12 clients from 5 different group homes to and from the Day Program by himself.</li> <li>- "I am new, and no one offered to help. I thought I was supposed to manage the situation as best as possible...It was becoming overwhelming."</li> </ul> <p>Interview 2/11/21 with the Licensee #1 revealed:</p> <ul style="list-style-type: none"> <li>- On 1/22/21 FC A6 was going home from the day program on the van. FC A6 stripped off his clothes and defecated on the van. FC A6 had</li> </ul>	V 112		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL034-309</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>03/12/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>INDEPENDENT LIVING AT RANSOM RD</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>355 RANSOM ROAD</b> <b>WINSTON SALEM, NC 27106</b>		
(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	Continued From page 5  attacked client #1 and client #3 on the van as well. Client #1 fought back and FC A6 got scratched. - She was aware that the treatment plans identified that for FC A6 and several of the clients who rode the van, they needed one on one care, but she indicated the clients did not "get one on one care during transport." -She was also aware of the client's issues and behaviors.  Interview on 2/18/21 with the Licensee for Facility A revealed: - She was the Licensee for the 5400 program (Day Activity - All Disabilities) which had minor children doing virtual learning with the adult program. - "They (the clients in virtual learning) only need one staff for the virtual learning."  This deficiency is cross referenced into 10A NCAC 27G .5602 Staff (V290) for a Type A1 rule violation and must be corrected within 23 days.	V 112			
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	V 290			

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  MHL034-309	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 03/12/2021
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  INDEPENDENT LIVING AT RANSOM RD	STREET ADDRESS, CITY, STATE, ZIP CODE 355 RANSOM ROAD WINSTON SALEM, NC 27106
---	---

(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>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 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, observations and interviews, the facility failed to ensure staff-client ratios enabled staff to respond to individualized client needs affecting 3 of 3 clients (#1, #2 and</p>	V 290	<p>The agency will ensure that staffing is done according to the needs of the</p>	

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL034-309</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>03/12/2021</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>INDEPENDENT LIVING AT RANSOM RD</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>355 RANSOM ROAD WINSTON SALEM, NC 27106</b>
--	---

(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>#3). The findings are:</p> <p>Cross Reference: 10A NCAC 27G .0205 Assessment and Treatment/Habilitation or Service Plan (V112) Based on record review, observations and interviews the facility failed to implement strategies for 3 of 3 clients (#1, #2 and #3).</p> <p>Review on 3/12/21 of the Plan of Protection dated 3/11/21 written by the Licensee #1 revealed: "What immediate action will the facility take to ensure the safety of the consumers in your care? Effective today agency will ensure that there is adequate staffing to meet the needs of the people we serve while they are receiving residential services as well as during transport. The agency will use the information provided in the ISP to determine what those needs are. Describe your plans to make sure the above happens. The Director will monitor the staffing patterns and work with the QP to ensure plans are being followed"</p> <p>The facility served three male clients ages 14 and 17 with various diagnoses not limited to: Autism; PTSD; ADHD; Moderate IDD; Reactive Attachment Disorder; Impulse Control Disorder; Suicidal Ideation; Bipolar Disorder; Disruptive Mood Dysregulation Disorder; and Pervasive Developmental Disorder (NOS). According to their treatment plans, two of the clients required 1:1 staffing or close supervision. The 3 clients were taken to a 5400 Day Program owned by the Licensee for virtual learning Monday-Friday from 8:30 am - 2:30 pm because they did not have a 1st shift staff at their group home. They were transported to and from the day program on a van that also transported adult clients of the program.</p>	V 290	<p>Client identified in the ISP. The agency will recruit, hire and train additional staff to ensure that the needs of the people we serve are being met. This will be ongoing and the Director and QP will be responsible for ensuring this takes place.</p>	4/5/21



Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL034-309</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>03/12/2021</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>INDEPENDENT LIVING AT RANSOM RD</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>355 RANSOM ROAD</b> <b>WINSTON SALEM, NC 27106</b>
--	---

(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>The adult 5400 program served adult clients, five of which had a history of inappropriate sexual behavior. Some of their histories included, exposing self in public, inappropriate gesturing and touching of children, aberrant sexual behavior including peeping and exposing self in public areas, sexual aggression which includes oral sex with a child. Nine of the adult clients had a history of serious aggressive and violent behavior and many required one-on-one supervision. While the 3 clients were at the adult 5400 program they were in the same room with 3 other clients from different group homes. All six clients were supervised by 1 staff who worked for the adult 5400 program and was not aware of their treatment needs, goals or strategies. This deficiency constitutes a Type A1 rule violation for serious neglect and must be corrected within 23 days. An administrative penalty of \$2,000.00 is imposed. If the violation is not corrected within 23 days, an additional administrative penalty of \$500.00 per day will be imposed for each day the facility is out of compliance beyond the 23rd day.</p>	V 290		