

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  R-C <b>05/03/2021</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 000}	<p><b>INITIAL COMMENTS</b></p> <p>A follow-up survey was completed on 5/3/21. Deficiencies were cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .5600B Supervised Living for Minors with Developmental Disability.</p>	{V 000}		
{V 112}	<p><b>27G .0205 (C-D)</b> <b>Assessment/Treatment/Habilitation Plan</b></p> <p><b>10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN</b></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"> <li>(1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement;</li> <li>(2) strategies;</li> <li>(3) staff responsible;</li> <li>(4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both;</li> <li>(5) basis for evaluation or assessment of outcome achievement; and</li> <li>(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.</li> </ol>	{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:  <b>MHL034-309</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R-C</b> <b>05/03/2021</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>This Rule is not met as evidenced by: Based on record review, and interviews the facility failed to implement strategies for 3 of 3 clients (#1, #2 and #3). The findings are:</p> <p>Review on 4/29/21 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 4/29/21 of client #2's record revealed: Admission Date: 9/22/17 Diagnoses: Autism; Attention Deficit Hyperactivity Disorder (ADHD); Reactive Attachment Disorder; 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." - Further review of client #2's goals from his 6/1/20 PCP revealed: "With assistance, [client #2] manage his emotions and uses his coping skills in all settings. How and how often (service/frequency): ...Day supports-individual/30 hours per week when not in school ...has multiple behavioral challenges that present when he becomes stressed including emotional outbursts, aggression toward others and property</p>	{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>R-C</b> <b>05/03/2021</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> <p>destruction, elopement, stealing, and self injury."</p> <p>Review on 4/29/21 of client #3's record revealed Admission Date:10/5/18 Diagnoses: Autism; Selective Mutism; and Psychomotor Disorder Age: 14 Review of client #3's PCP dated 8/1/20 revealed: " ... requires 24/7 supervision and consistent care due to his Autism Spectrum Disorder ...[Client #3] requires close supervision due to him having the ability to wander off. 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." - Further review of client #3's goals from his 8/1/20 PCP revealed: "[Client #3] will refrain from eloping ...Staff will always keep [client #3] within arm's length ...[Client #3] doesn't pay attention to his surroundings and easily put himself into danger."</p> <p>Review on 4/29/21 of incident reports revealed: - Client #1 eloped from the group home and the group home staff contacted the police. The police did a silver alert (Amber alert). Client #1 was able to walk to the local hospital (5 miles away) and stayed overnight prior to his father picking him up at the hospital and returning him to the group home.</p> <p>Interview on 4/28/21 with client #1 revealed: - One staff worked each shift on the weekends. - When he eloped from the group home one staff was on shift and cooking in the kitchen. - He was unsure how many staff worked each shift during the week.</p> <p>Interview on 4/28/21 with client #2 revealed: - One staff worked each shift during the week and</p>	{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  R-C <b>05/03/2021</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 112}	<p>Continued From page 3</p> <p>weekends.</p> <ul style="list-style-type: none"> <li>- "We are good kids, so they only need one (staff)"</li> <li>- "When we wake up and go to bed there is only one staff here."</li> </ul> <p>Attempted interview on 4/28/21 with client #3 revealed: Client #3 was unable to respond to any questions due to his inability to communicate.</p> <p>Interview on 4/28/21 with staff #1 revealed:</p> <ul style="list-style-type: none"> <li>- During the week there were two staff who worked each shift.</li> <li>- During the weekend there was one staff who worked each shift.</li> <li>- Client #3 required "one on one care."</li> <li>- "I just work here. I guess the administrative people are working on that (ensuring client #3 has a one on one)."</li> </ul> <p>Interview on 4/29/21 with staff #4 revealed:</p> <ul style="list-style-type: none"> <li>- She felt client #3 needed a one on one.</li> <li>- During the week there were two staff who worked each shift.</li> <li>- On the weekends, one staff worked daytime and one staff worked at night.</li> </ul> <p>Interview on 4/30/21 with the Qualified Professional (QP) revealed:</p> <ul style="list-style-type: none"> <li>- During the month of April 2021 there were two weekends that only one staff worked each shift due to a staff "calling out."</li> <li>- He could not recall which weekends in April 2021 that one staff worked each shift.</li> </ul> <p>Interview on 5/3/21 with the Licensee revealed:</p> <ul style="list-style-type: none"> <li>- She had difficulty hiring new staff and having enough staff on duty due to: COVID (coronavirus disease) and people wanted to collect</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  R-C <b>05/03/2021</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 112}	Continued From page 4  unemployment rather than work.  This deficiency constitutes a re-cited deficiency.  This deficiency is cross referenced into 10A NCAC 27G .5602 Staff (V290) for a Type B rule violation and must be corrected within 45 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 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	{V 290}		

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  R-C <b>05/03/2021</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 5</p> <p>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, 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 #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 5/3/21 of the Plan of Protection dated 5/3/21 written by the Qualified Professional (QP) revealed: "What immediate action will the facility take to ensure the safety of the consumers in your care? Effective 5/3/2021 Independent Living @ Ransom Rd will be staffed according to all consumers treatment plans; staff client ratio will</p>	{V 290}		

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>R-C</b> <b>05/03/2021</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 6</p> <p>be determined by the needs in plan. A client who specially gets a one on one will have a staff. The agency will revamp schedule to ensure weekend is staffed adequately. The agency will work with the clients care team to better specify in plans the duration of services to ensure all the people we serve needs are met. The agency acknowledges and understands the importance of staffing adequately to better assist with strategies to minimize problems and to ensure everyone's safety.</p> <p>Describe your plans to make sure the above happens. To meet the needs of the clients the agency will require mandatory overtime on the weekends to ensure staffing is adequate. The agency will continue to recruit new staff and offer incentives for current staff."</p> <p>This deficiency constitutes a re-cited deficiency.</p> <p>The facility served three male clients ages 14 and 17 with various diagnoses not limited to: Autism; Selective Mutism; Psychomotor Disorder; PTSD; IDD; ADHD; 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 staff and clients reported on the weekends there was only one staff who worked each shift. Client #1 reported he was able to elope from the group home when the one staff who was on shift was in the kitchen cooking. Client #2 and client #3 have treatment plans that indicate they need one on one staffing due to elopement and safety issues.</p> <p>This deficiency constitutes a Type B rule violation as it is detrimental to the health, safety and</p>	{V 290}		

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>R-C</b> <b>05/03/2021</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}	Continued From page 7  welfare of the clients. If the violation is not corrected within 45 days, an administrative penalty of \$200.00 per day will be imposed for each day the facility is out of compliance beyond the 45th day.	{V 290}		