STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL034-380	A. BUILDING: _____ B. WING _____	R 07/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHARPE AND WILLIAMS #8	937 GLENCOE STREET WINSTON SALEM, NC 27107

(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 An annual, complaint and follow up survey was completed on 7/23/2021. The complaint was substantiated (intake #NC178909). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600A Supervised Living for Adults with Mental Illness.	V 000	V110 - incident report was submitted in IRIS and internal investigation along of HCR report was also updated in IRIS Report. V120 - All medications external and internal will be stored per written policy. V131 - HCR report will be obtain 5 day prior to date of hire. V132 - proof of HCR Report notification was uploaded into IRIS. V133 - criminal histon will be obtain 5 days prior to date of hire. V367 incident report regarding This incident and future	
V 110	27G .0204 Training/Supervision Paraprofessionals 10A NCAC 27G .0204 COMPETENCIES AND SUPERVISION OF PARAPROFESSIONALS (a) There shall be no privileging requirements for paraprofessionals. (b) Paraprofessionals shall be supervised by an associate professional or by a qualified professional as specified in Rule .0104 of this Subchapter. (c) Paraprofessionals shall demonstrate knowledge, skills and abilities required by the population served. (d) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence. (e) Competence shall be demonstrated by exhibiting core skills including: (1) technical knowledge; (2) cultural awareness; (3) analytical skills; (4) decision-making; (5) interpersonal skills; (6) communication skills; and (7) clinical skills. (f) The governing body for each facility shall develop and implement policies and procedures for the initiation of the individualized supervision	V 110		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Keshia Spaulding

TITLE: Agency Director

(X6) DATE: 8/15/21

Division of Health Service Regulation

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V 110	Continued From page 1 plan upon hiring each paraprofessional. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure paraprofessionals demonstrated knowledge, skills and abilities required by the population served affecting 1 of 1 Former Staff (FS #2). The findings are: Review on 7/14/2021 of FS #2's employee record revealed: - Date of Hire: 1/21/2021 - Date of Separation: 7/2/2021 - Documentation of orientation training, including emergency procedures, on 1/21/2021. Review on 7/15/2021 of Client #5's record revealed: - Date of admission: 10/12/2013 - Diagnoses: Schizoaffective Disorder; Mood Disorder NOS (not otherwise specified); Post Traumatic Stress Disorder; Epilepsy; and Scoliosis Review on 7/16/2021 of an email sent by the Qualified Professional (QP) to the Director on 7/2/2021 revealed: - "On 07/01/2021 at 9:40pm the [local emergency management services (EMS)] responded to [the facility address], due to [Client #5] having a seizure. Once EMS arrive, they noticed that there was not a staff present at the home. EMS proceeded to call the [local] police department. The police responded and arrived to the home	V 110	incident will be submitted to DHS within the proper time frame V736 – odor of urine was present due to one client that has Constant incontinence BSCs. New plans has been put in place by QP to address the BSC. The QP has reached out to guardian to create a positive reinforcement initative of the client to gain control of bowel & bladder. QP has also motivated guardian that if client belongings are above repair the facility will request that the items are replaced. This item has been had to clients to log.	

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V 110	Continued From page 2 around 10:00pm. [The QP] was notified around 9:40pm and arrived at the home at 10:20pm (Arriving from [a different city]). EMS was already gone once the QP arrived. They assessed [Client #5] before leaving and he was okay and did not need to go to the hospital. The police stayed on the scene until [the QP] arrived. Once she arrived the police did a report on the staff that left the consumers unattended, [FS #2]. Once the police left the home the staff, [FS #2] arrived back to the home around 11:00pm. Once she arrived back to the home she was immediately terminated." Review on 7/23/2021 of a copy of an IRIS report form provided by the QP revealed: - An 11-page IRIS report form that listed a submission date of 7/2/2021. - The form was partially filled out with multiple fields blank. - "The cause of the incident was due to client neglect by staff on duty (FS #2)." - "Incident Prevention: Terminate staff member immediately and continue to abide by set policy and procedure." - No information was present that described the details of the incident. Interview attempt on 7/14/2021 with Client #4 revealed: - He shook his head "no" to every questioned and could not provide any details regarding the 7/1/2021 incident. Interview on 7/14/2021 with Client #5 revealed: - On 7/1/2021, the staff working that evening (FS #2) had left client alone at the facility. - When FS #2 returned, she was fired. - He could not remember the details of the incident.	V 110	V110 continued: facility repairs have been conducted on the following items - hole in kitchen drywall - handle to laundry repaired - all items in clients room removed or properly stored. - vent intake on ceiling cleaned. - blind in bedroom #3 & 5 replaced - toilet repaired V760 - bedside storage tables have been placed in each client room	

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V 110	Continued From page 3 Attempts were made on 7/13/2021 and 7/23/2021 to contact the Police Officer involved with the 7/1/2021 incident, but no response to messages requesting a return phone call was received by the time of exit. Interview on 7/23/2021 with FS #2 revealed: - On 7/1/2021, she had to leave the facility because of an emergency. - She could not remember details of the emergency other than "it was something with my niece ... She had to be rushed to the hospital." - Her niece had been at the facility at the time of the emergency. - She did not respond to any other questions from the Surveyor, and the call was terminated. - She did not respond to attempts by the Surveyor to reach her again. Interviews on 7/15/2021 and 7/16/2021 with the QP revealed: - On 7/1/2021, FS #2 told her that her sister had visited FS #2 at the facility with the sister's one-year-old daughter in order to take food to FS #2. - FS #2's niece had a seizure while at the facility. - FS #2 left the facility with her sister in order to take her niece to a local hospital. - FS #2 had not contacted any facility management staff to inform them that she was leaving. - After FS #2 left the facility, Client #5 had a seizure. - Client #4 called EMS for Client #5. - She had gotten a call from local Police to inform her of the incident. - She had gone to the facility and worked the rest of FS #2's shift. - When FS #2 returned to the facility, she was terminated immediately.	V 110		