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 SURVEY COMPLETED	
MHL073034		B. WING		09	09/13/2021		
NAME OF F	PROVIDER OR SUPPLIER			TY, STATE, ZIP CODE			
MAIN ST	REET GROUP HOME		TH MAIN S				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION	DRE	(X5) COMPLETE DATE	
V 000	INITIAL COMMENT	S	V 000				
	13, 2021. A deficience This facility is license category: 10A NCAC	as completed on September by was cited. ed for the following service 27G .5600C Supervised Developmental Disabilities.					
V 736	27G .0303(c) Facility	and Grounds Maintenance	V 736				
(r n	10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS (c) Each facility and its grounds shall be maintained in a safe, clean, attractive and orderly manner and shall be kept free from offensive odor.			DHSR - Mental Healt SEP 2 4 2021 Lic. & Cert. Section			
fa in	ailed to ensure facility	as evidenced by: and interview, the facility grounds were maintained tractive manner. The					
-C	lient #4's bedroom re	1 at about 12:00 pm of evealed: n spots throughout the					
roo rev -C	om located on right s vealed:	1 at about 12:03 pm of side of the hallway					
Ob	oservation on 9/13/21 ient #5's bedroom rev	at about 12:05 pm of /ealed:					

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

TITLE

(X6) DATE

Division of Health Service Regulation

STATEME AND PLAI	NT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA N OF CORRECTION INMEDIA		(X2) MULTIF	PLE CONSTRUCTION	(V2) DAT	F 011511-11	
		IDENTIFICATION NUMBER:		A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL073034	B. WING				
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS CITY	STATE, ZIP CODE	1 09/	13/2021	
AIN ST	REET GROUP HOME		TH MAIN ST				
			O, NC 2757				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL IC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLE DATE	
V 736	Continued From pag	ge 1	V 736			-	
		stain spots all throughout the	V 700				
	Client #2's bedroom	cant number of stains all					
	Client #1's bedroom i	21 at about 12:10 pm of revealed: cant number of stains all					
-	Client #3's bedroom r	21 at about 12:13 pm of evealed: ant number of stains all					
	-iving area revealed: Carpet had a significa hroughout the room.	21 at about 12:15 pm of the ant number of stains all et next to entrance was ust showing threads.					
n	allways revealed:	1 at about 12:17 pm of the					
ar -T	nd the Services Direc hey were aware that	the carpet at the house					
-H an -H	UD was responsible	Department of Housing of (HUD).					
rep an	me and replacing the gency had put in a tic	carpets. ket to HUD already about ut they did not know when					

Division of Health Service Regulation

KPQC11

Division of Health Service Regulation

THE PERIOD CONNECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DAT COM	E SURVEY PLETED
		MHL073034				
NAME OF PROVIDER OR SUPPLIER STREET ADD		DDRESS, CITY, STATE, ZIP CODE		[09/	13/2021	
MAIN S	TREET GROUP HOME	411 SOU	TH MAIN STR	FET		
	THE THOUSE	ROXBO	RO, NC 27573			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	I CHOIL D DE	(X5) COMPLET DATE
V 736	-It had been their ex sometimes took a lo that had broken dow -They acknowledge	periences that HUD nger time to replace things n at the house. that facility failed to ensure	V 736	DEFICIENCY)		

Division of Health Service Regulation

PRINTED: 09/13/2021 FORM APPROVED

Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING: COMPLETED MHL073034 B. WING 09/13/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE MAIN STREET GROUP HOME 411 SOUTH MAIN STREET ROXBORO, NC 27573 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (X5)**PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG COMPLETE TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) V 000 INITIAL COMMENTS V 000 An annual survey was completed on September 13, 2021. A deficiency was cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities. V 736- The Operations Director sent 10/30/21 V 736 27G .0303(c) Facility and Grounds Maintenance V 736 a request via email on 9/15/21 to the 10A NCAC 27G .0303 LOCATION AND property manager at ARC requesting EXTERIOR REQUIREMENTS consideration for new flooring (c) Each facility and its grounds shall be throughout the facility. There will be maintained in a safe, clean, attractive and orderly manner and shall be kept free from offensive estimates obtained submitted to ARC to replace the flooring. While we await an approval by ARC the Operations Director will schedule a steam carpet cleaning by professional company. This Rule is not met as evidenced by: Program Coordinators will monitor Based on observation and interview, the facility the homes for a safe, clean, failed to ensure facility grounds were maintained in a clean, safe and attractive manner. The attractive and orderly manner and findings are: free from offensive odor. The Program Coordinator will report to Observation on 9/13/21 at about 12:00 pm of the Operations Director for any Client #4's bedroom revealed: -Carpet had a few stain spots throughout the repairs needed or cleanings. room. Observation on 9/13/21 at about 12:03 pm of room located on right side of the hallway revealed: -Carpet had a significant number of stain spots all throughout the room. Observation on 9/13/21 at about 12:05 pm of Client #5's bedroom revealed: Division of Health Service Regulation LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

PRINTED: 09/13/2021 FORM APPROVED (X3) DATE SURVEY Division of Health Service Regulation (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA COMPLETED STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: A. BUILDING: _ AND PLAN OF CORRECTION 09/13/2021 B. WING MHL073034 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **411 SOUTH MAIN STREET** MAIN STREET GROUP HOME ROXBORO, NC 27573 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) TAG V 736 Continued From page 1 V 736 -Carpet had several stain spots all throughout the room. Observation on 9/13/21 at about 12:08 pm of Client #2's bedroom revealed: -Carpet had a significant number of stains all throughout the room. Observation on 9/13/21 at about 12:10 pm of Client #1's bedroom revealed: -Carpet had a significant number of stains all throughout the room. Observation on 9/13/21 at about 12:13 pm of Client #3's bedroom revealed: -Carpet had a significant number of stains all throughout the room. Observation on 9/13/21 at about 12:15 pm of the Living area revealed: -Carpet had a significant number of stains all throughout the room. -Carpet in front of closet next to entrance was heavily worn out and just showing threads. Observation on 9/13/21 at about 12:17 pm of the hallways revealed: -Carpet had several stain spots all throughout Interview on 9/13/21 with the Clinical Supervisor and the Services Director revealed: -They were aware that the carpet at the house

needed to be replaced.

and Urban Development (HUD).

home and replacing the carpets.

-Home belonged to the Department of Housing

-HUD was responsible for doing repairs to the

-Agency had put in a ticket to HUD already about replacing the carpets, but they did not know when

PRINTED: 09/13/202

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES			FORM APPROVEL
AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:	(X3) DATE SURVEY COMPLETED
	MHL073034	B. WING	
NAME OF PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE, ZIP CODE	09/13/2021
BEALL OTTO	12 (27) (28)		

MAIN STREET GROUP HOME

	TREET GROUP HOME 411 SO	OUTH MAIN STR ORO, NC 27573		
(X4) ID PREFIX TAG	(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) COMPLE DATE
V 736	Continued From page 2	V 736		
	-It had been their experiences that HUD sometimes took a longer time to replace things that had broken down at the houseThey acknowledge that facility failed to ensure facility grounds were maintained in a clean, safe and attractive manner.	V 736		
	Service Regulation			

If continuation sheet 3 of 3



ROY COOPER · Governor

MANDY COHEN, MD, MPH · Secretary

MARK PAYNE • Director, Division of Health Service Regulation

September 15, 2021

DHSR - Mental Health

Melissa Day, Clinical Director Person County Group Homes, Inc. PO Box 721 Roxboro, NC 27573

Lic. & Cert. Section

Annual Survey completed September 13, 2021

Main Street Group Home, 411 South Main Street, Roxboro, NC 27573

MHL # 073-034

E-mail Address: Melissa.day@pcghinc.org

Dear Ms. Dav:

Thank you for the cooperation and courtesy extended during the Annual survey completed September 13,

Enclosed you will find all deficiencies cited listed on the Statement of Deficiencies Form. The purpose of the Statement of Deficiencies is to provide you with specific details of the practice that does not comply with state regulations. You must develop one Plan of Correction that addresses each deficiency listed on the State Form, and return it to our office within ten days of receipt of this letter. Below you will find details of the type of deficiencies found, the time frames for compliance plus what to include in the Plan of

Type of Deficiencies Found

Tag cited is a standard level deficiency.

Time Frames for Compliance

Standard level deficiency must be corrected within 60 days from the exit of the survey, which is

What to include in the Plan of Correction

- Indicate what measures will be put in place to correct the deficient area of practice (i.e. changes in policy and procedure, staff training, changes in staffing patterns, etc.).
- Indicate what measures will be put in place to prevent the problem from occurring again.
- Indicate who will monitor the situation to ensure it will not occur again.
- Indicate how often the monitoring will take place.
- Sign and date the bottom of the first page of the State Form.

MENTAL HEALTH LICENSURE & CERTIFICATION SECTION NC DEPARTMENT OF HEALTH AND HUMAN SERVICES • DIVISION OF HEALTH SERVICE REGULATION

LOCATION: 1800 Umstead Drive, Williams Building, Raleigh, NC 27603 MAILING ADDRESS: 2718 Mail Service Center, Raleigh, NC 27699-2718 www.ncdhhs.gov/dhsr • TEL: 919-855-3795 • FAX: 919-715-8078

September 15, 2021 Person County Group Homes, Inc. Melissa Day

Make a copy of the Statement of Deficiencies with the Plan of Correction to retain for your records. Please do not include confidential information in your plan of correction and please remember never to send confidential information (protected health information) via email.

Send the original completed form to our office at the following address within 10 days of receipt of this

Mental Health Licensure and Certification Section NC Division of Health Service Regulation 2718 Mail Service Center Raleigh, NC 27699-2718

A follow up visit will be conducted to verify all violations have been corrected. If we can be of further assistance, please call Bryson Brown, Team Leader at 919-855-3822.

Sincerely.

Edgar Garrido, MSW

Facility Compliance Consultant I

Mental Health Licensure & Certification Section

Cc:

qmemail@cardinalinnovations.org Pam Pridgen, Administrative Assistant

File