Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING MHL063-091 08/18/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **340 MIDDLETON STREET** MIDDLETON STREET ROBBINS, NC 27325 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5)(EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE **PREFIX** PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) V 000 INITIAL COMMENTS V 000 An annual and complaint survey was completed on August 18, 2021. The complaints were DHSR - Mental Health substantiated (intake #NC00180211 and intake #NC00180225). Deficencies were cited. SEP 2 9 2021 The facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Lic. & Cert. Section Living for Adults with Developmental Disabilities. V 108 27G .0202 (F-I) Personnel Requirements V 108 All staff will be trained in cardiopulmonary 10/19/2021 10A NCAC 27G .0202 PERSONNEL resuscitation (CPR) provided by American REQUIREMENTS Red Cross to include participation in in-(f) Continuing education shall be documented. (g) Employee training programs shall be person skills sessions. provided and, at a minimum, shall consist of the Monarch's Education Department will following: ensure staff are trained according to (1) general organizational orientation: 27.G.0202 (F-I) Personnel Requirements. (2) training on client rights and confidentiality as delineated in 10A NCAC 27C, 27D, 27E, 27F and Monarch's Education Department will 10A NCAC 26B: monitor required trainings by running (3) training to meet the mh/dd/sa needs of the reports weekly for trainings due in 60 days client as specified in the treatment/habilitation plan; and which will alert staff and managers of (4) training in infectious diseases and upcoming trainings needed to include CPR. bloodborne pathogens. (h) Except as permitted under 10a NCAC 27G .5602(b) of this Subchapter, at least one staff member shall be available in the facility at all times when a client is present. That staff member shall be trained in basic first aid including seizure management, currently trained to provide cardiopulmonary resuscitation and trained in the Heimlich maneuver or other first aid techniques such as those provided by Red Cross, the American Heart Association or their equivalence for relieving airway obstruction. (i) The governing body shall develop and

Division of Health Service Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

implement policies and procedures for identifying,

TITLE

(X6) DATE

STATE FORM

Director of Regulatory affairs 09/23/2021

FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: _ B. WING MHL063-091 08/18/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **340 MIDDLETON STREET** MIDDLETON STREET ROBBINS, NC 27325 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) V 108 Continued From page 1 V 108 Page intentionally left blank reporting, investigating and controlling infectious and communicable diseases of personnel and clients. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure staff were currently trained in cardiopulmonary resuscitation (CPR) provided by the American Red Cross, the American Heart Association or their equivalence affecting 3 of 3 audited staff (#4, #5 and the Qualified Professional) and 1 of 1 former staff (Former Staff #6). The findings are: Review on 8/18/21 of staff #4's personnel record revealed: -Hire date of 3/29/21. -Training in CPR was dated 4/1/21. Review on 8/18/21 of staff #5's personnel record revealed: -Hire date of 8/28/17 -Training in CPR was dated 10/4/20. Review on 8/18/21 of the QP's personnel record

-Hire date of 12/18/17.

revealed:

-Training in CPR was dated 11/12/19.

Review on 8/18/21 of FS #6's personnel record revealed:

-Hire date of 2/15/16.

- -Date of separation was 8/16/21.
- -Training in CPR was dated 3/3/20.

Division of Health Service Regulation

STATE FORM

(X3) DATE SURVEY

Division of Health Service Regulation

(X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES

AND FLAN OF CORRECTION		OF CORRECTION	A. BUILDING:		G:	COMPLETED	
L			MHL063-091	B. WING _		08/	18/2021
		PROVIDER OR SUPPLIER TON STREET	340 MIDD	DRESS, CITY DLETON ST B, NC 2732			
	(X4) ID PREFIX TAG	(EACH DEFICIENCY I	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETE DATE
		Interview on 8/18/21 -Prior to COVID, trai -CPR training was or -Doing chest compressions dicking the computer on 8/18/21 -All trainings were been compressions clicking the computer on the same of the computer of the compu	with staff #1 revealed: nings were completed online. ompleted online. essions using a computer with the QP revealed: eing completed online. were demonstrated by er mouse. d to ensure appropriate hand ent/Habilitation Plan 5 ASSESSMENT AND LITATION OR SERVICE shall be completed for a overning body policy, prior to es, and shall include, but not enting problem; s and strengths; admitting diagnosis with an s determined within 30 days that a client admitted to a r 24-hour medical program shed diagnosis upon , family, and medical history; esessments, such as e abuse, medical, and oriate to the client's needs. e provided prior to the		Residential Team Leaders will completed Admission Assessment on the day of admission to include: Admission Date Presenting Problems, 2. Needs and Strengths, 3. Diagnosis, 4. Pertinent family and medical history Monarch will include in the LTSS Admission for the EHR an Admission Assessment that will be completed at admission to services. Director of Program Operations will may quarterly during peer review audits to include new admissions for the quarter	fe, 1. social, mission on	10/19/2021

(X2) MULTIPLE CONSTRUCTION

Division of Health Service Regulation STATEMENT OF DEFICIENCIES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION 5:		SURVEY PLETED
	MHL063-091	B. WING		08/	18/2021
NAME OF PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY,	STATE, ZIP CODE		
MIDDLETON STREET		LETON STR , NC 27325			
PREFIX (EACH DEFICIENCY M	EMENT OF DEFICIENCIES UST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPROFICIENCY)	D BE	(X5) COMPLETE DATE
This Rule is not met a Based on record revise failed to ensure an asprior to the delivery of audited clients (#1). Review on 8/17/21 of the following: -Date of admission 6/-Diagnoses include M Disability, Down Synd ObesityThere was no assess client #1's needs, streepresenting problems. Interview on 8/18/21 of Professional revealed She was not sure why completed.	as evidenced by: ew and interview, the facility seessment was completed f services affecting 1 of 3 The findings are: client #1's record revealed 15/21. loderate Intellectual rome, Hypothyroidism and sment or documentation of engths and identified with the Qualified : y an assessment was not entified the presenting	V111	Page intentionally left blank		

Division of Health Service Regulation
STATEMENT OF DEFICIENCIES (X1) PROV

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G:		E SURVEY IPLETED
		MHL063-091	B. WING		08/	18/2021
(X4) ID PREFIX TAG	(EACH DEFICIENCY REGULATORY OR L	340 MIDD ROBBINS ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	DETON STI 5, NC 27325 ID PREFIX TAG		D BE	(X5) COMPLETE DATE
V 112	10A NCAC 27G .020 TREATMENT/HABI PLAN (c) The plan shall be assessment, and in legally responsible profession for clie receive services begin (d) The plan shall in (1) client outcome(seachieved by provision projected date of acceptance (2) strategies; (3) staff responsible (4) a schedule for manually in consultative responsible person (5) basis for evaluation outcome achievement (6) written consent responsible party, or	nent/Habilitation Plan O5 ASSESSMENT AND ILITATION OR SERVICE De developed based on the partnership with the client or person or both, within 30 days ents who are expected to yond 30 days. Include: S) that are anticipated to be on of the service and a chievement; E; Eview of the plan at least tion with the client or legally or both; Ition or assessment of ent; and or agreement by the client or r a written statement by the such consent could not be	V112 V112	Residential Team Leader will follow Monarch's Policy on Person Center Planning to include obtaining the Le Responsible Person's signature and prior to implementing the plan. DPO will monitor plan signatures de quarterly peer reviews	red egally I date	10/19/2021
	Based on record rev failed to ensure one #1) treatment plan re	iew and interview, the facility of three audited clients (client eceived written consent and guardian. The findings are:				

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		MHL063-091	B. WING _		08/	18/2021
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY	, STATE, ZIP CODE	00/	10/2021
MIDDLE	TON STREET		, NC 2732			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
V 112	Review on 8/17/21 of -Date of admission of -Diagnoses include Disability, Down Syr ObesityTreatment plan was -The guardian signal Interview on 8/17/21 Professional revealershe thought the tree by the guardianShe had to reach or requesting a signature-She was responsible.	of client #1's record revealed: 6/15/21. Moderate Intellectual adrome, Hypothyroidism and a developed on 6/15/21. ture was dated 8/3/21. with the Qualified ed: atment plan had been signed out to the guardian on 8/3/21 are. e for ensuring treatments	V112			
	plan signed. 27G .0209 (F) Medic 10A NCAC 27G .0209 REQUIREMENTS (f) Medication review (1) If the client received your operation of the component of the component of the client's physician. The on-site the client's physician the review when medical the findings of the component of the client's physician the review when medical the component of the client's physician the review when medical the component of th	failed to have the treatment sation Requirements MEDICATION The responsible of each client's drug ry six months. The review med by a pharmacist or the manager shall assure that is informed of the results of dical intervention is indicated. The review shall ent record along with		In review of the completed 6-month Pharmacy Review form, while done in practice, the form does not indicate th review of psychotropic medication. Monarch's LTSS Nursing Supervisor versuest Kerr Drug to include a statement their Pharmacy Review form to indicate meds are reviewed including Psychotrom Medications. Manager will continue to review the outcomes of the 6-month Pharmacy Reviews and assure the client's physic informed of the results when medical intervention is indicated.	e will ent on te all ropic	10/19/2021

Division of Health Service Regulation (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN	PLE CONSTRUCTION G:		SURVEY PLETED
	MHL063-091		B. WING		08/18/2021	
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
MIDDLE	TON STREET		LETON ST			
(X4) ID PREFIX TAG	(EACH DEFICIENCY I	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPED DEFICIENCY)) BE	(X5) COMPLETE DATE
V 121	Continued From page	ge 6	V 121	Page intentionally left blank		
	failed to obtain drug	riew and interview, the facility reviews every six months for clients (#2) who received				
	-Admission date of 6 -Diagnoses of Mild In Syndrome, Hyperter	of client #2's record revealed: 6/1/11. Intellectual Disability, Down Insion, Hyperlipidemia, Fastroesophageal Reflux				
		ence of a six-month ation review for client #2.				
	8/17/21 revealed: -Order dated 10/7/20	orders for client #2 on) for Risperidone 3 milligram ablet on the tongue at				
	Record (MAR) on 8/1 -August 2021- Client medication on 8/1 th -July 2021- Client wa medication on 7/1 the	was administered the above ru 8/16. Is administered the above ru 7/31. Is administered the above				
	Interview on 8/18/21 Professional revealer-She was not aware or She looked in client documentation from She would contact the She confirmed the serview was not compatible.	d: of what this entailed. chart and saw no the psychiatrist. ne pharmacy. ix-month psychotropic drug				

(X2) MULTIPLE CONSTRUCTION

PRINTED: 09/07/2021 FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: _ B. WING MHL063-091 08/18/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 340 MIDDLETON STREET MIDDLETON STREET ROBBINS, NC 27325 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) V 736 27G .0303(c) Facility and Grounds Maintenance V 736 The Residential Team Leader had the 10/19/2021 10A NCAC 27G .0303 LOCATION AND Hallway lightbulb replaced **EXTERIOR REQUIREMENTS** (c) Each facility and its grounds shall be -Client # 2 was informed that staff will need maintained in a safe, clean, attractive and orderly to assist her with cleaning her room manner and shall be kept free from offensive including replacing her mattress cover and pillows and relocating the totes and personal items blocking her window to provide her easy access to exit in case of a The Residential Team Leader followed up This Rule is not met as evidenced by: on Facility Work Orders to assure they were Based on observation and interview, the facility complete failed to ensure facility grounds were maintained The missing electrical socket cover has in a safe, clean, attractive orderly manner and been replaced kept free from offensive odor. The findings are: -Backyard- the black office chair and the broken walker have been removed Observation on 8/18/21 at approximately -Outside office door entrance - lightbulb has 11:40am at the facility revealed the following: been replaced. -Hallway light had a blown lightbulb. -Client #2 bedroom smelled of urine; the mattress The Residential Manager or designee will cover was heavily discolored and soiled; pillows, ensure that the facility is maintained in a totes and personal items blocked the window safe, clean and attractive manner and free access if needed to exit due to fire. of offensive odor when completing the -Hallway towards backyard exit- missing an monthly environmental inspection. Work electrical socket cover. Orders will be completed immediately after -Backyard- A black office chair sitting by garbage discovering an issue. bin and And broken walker leaning against the exterior of the house by the garbage bin.

Division of Health Service Regulation

smelling of urine.

her window.

-Outside office door entrance- Lightbulb blown.

Interview on 8/17/21 with staff #1 revealed: -He mentioned to management need for a new

mattress cover and possible for client room

Once a maintenance order is requested for

-He reminded client daily to move items blocking

months.

The Residential Manager will provide the

Director of Program Operations monthly Environmental Checklist for the next 3

PRINTED: 09/07/2021 FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: ___ B. WING MHL063-091 08/18/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 340 MIDDLETON STREET **MIDDLETON STREET** ROBBINS, NC 27325 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) V 736 Continued From page 8 V 736 Page intentionally left blank house repairs, maintenance comes to address the identified issues. -Maintenance had been to the home to power wash and did not pick up the items on the back porch or replace lightbulbs. Interview on 8/18/21 with Qualified Professional revealed: -She confirmed there was a maintenance department that comes out to repair things in the home. -She thought maintenance had picked up the items on the back porch. -She confirmed facility staff failed to ensure facility grounds were maintained in a safe, clean, attractive, orderly manner and kept free from offensive odor.

PRINTED: 09/07/2021 FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:	(X3) DATE SURVEY COMPLETED
	MHL063-091	B. WING	08/18/2021

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BUILDIN	G:		" LL I LD
		MHL063-091	B. WING		08/	18/2021
NAME OF PROVID	ER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
MIDDLETON S	TREET		LETON ST 5, NC 2732			
	ACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETE DATE
Intental Priority Control Priority Contr	r to COVID, training was on the compressions of the computer training failed ment. 10205 (A-B)	1 with staff #1 revealed: inings were completed online. completed online. ressions using a computer 1 with the QP revealed: reing completed online.		Residential Team Leaders will comp Admission Assessment on the day o admission to include: Admission Dat Presenting Problems, 2. Needs and Strengths, 3. Diagnosis, 4. Pertinent family and medical history Monarch will include in the LTSS Adi Group Forms in the EHR an Admissi Assessment that will be completed a admission to services. Director of Program Operations will in quarterly during peer review audits to include new admissions for the quart	social, mission on t	10/19/2021

PRINTED: 09/07/2021 FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: _ B. WING MHL063-091 08/18/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 340 MIDDLETON STREET MIDDLETON STREET ROBBINS, NC 27325 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) V 111 V 111 Continued From page 3 Page intentionally left blank referred to as the "plan," strategies to address the client's presenting problem shall be documented. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure an assessment was completed prior to the delivery of services affecting 1 of 3 audited clients (#1). The findings are: Review on 8/17/21 of client #1's record revealed the following: -Date of admission 6/15/21. -Diagnoses include Moderate Intellectual Disability, Down Syndrome, Hypothyroidism and Obesity. -There was no assessment or documentation of client #1's needs, strengths and identified presenting problems. Interview on 8/18/21 with the Qualified Professional revealed:

Division of Health Service Regulation

completed.

-She was not sure why an assessment was not

-She gathered the application and psychological evaluation both dated prior to admission. -Neither document identified the presenting problem and current needs of the client.

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING	G:	СОМ	PLETED	
MHL063-091		B. WING	B. WING		18/2021		
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE			
MIDDLE	TON STREET		LETON STI				
(VA) ID	SUMMARY STA	TEMENT OF DEFICIENCIES			241	T	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIES DEFICIENCY)) BE	COMPLETE DATE	
V 112	Continued From pa	ge 4	V 112				
V 112	27G .0205 (C-D)		V 112				
		nent/Habilitation Plan	1 (2.2.				
	Continued From page 4 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 obtained.			Residential Team Leader will follow Monarch's Policy on Person Centered Planning to include obtaining the Leader Responsible Person's signature and prior to implementing the plan. DPO will monitor plan signatures duquarterly peer reviews	ed egally date	10/19/2021	
	failed to ensure one (#1) treatment plan re	as evidenced by: iew and interview, the facility of three audited clients (client eceived written consent and juardian. The findings are:					

PZU011

PRINTED: 09/07/2021 FORM APPROVED Division of Health Service Regulation (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: B. WING MHL063-091 08/18/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 340 MIDDLETON STREET MIDDLETON STREET ROBBINS, NC 27325 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5)(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) V 112 Continued From page 5 V 112 Review on 8/17/21 of client #1's record revealed: -Date of admission 6/15/21. -Diagnoses include Moderate Intellectual Disability, Down Syndrome, Hypothyroidism and Obesity. -Treatment plan was developed on 6/15/21. -The guardian signature was dated 8/3/21. Interview on 8/17/21 with the Qualified Professional revealed: -She thought the treatment plan had been signed by the guardian. -She had to reach out to the guardian on 8/3/21 requesting a signature. -She was responsible for ensuring treatments plans were completed and signed. -She confirmed she failed to have the treatment plan signed. V 121 27G .0209 (F) Medication Requirements V 121 10A NCAC 27G .0209 MEDICATION REQUIREMENTS In review of the completed 6-month 10/19/2021 (f) Medication review: Pharmacy Review form, while done in (1) If the client receives psychotropic drugs, the practice, the form does not indicate the governing body or operator shall be responsible review of psychotropic medication. for obtaining a review of each client's drug regimen at least every six months. The review Monarch's LTSS Nursing Supervisor will shall be to be performed by a pharmacist or request Kerr Drug to include a statement on physician. The on-site manager shall assure that their Pharmacy Review form to indicate all the client's physician is informed of the results of meds are reviewed including Psychotropic

Division of Health Service Regulation

the review when medical intervention is indicated.

(2) The findings of the drug regimen review shall be recorded in the client record along with

corrective action, if applicable.

Medications.

Manager will continue to review the

outcomes of the 6-month Pharmacy

intervention is indicated.

Reviews and assure the client's physician is informed of the results when medical

Division of Health Service Regulation
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	1	G:		IPLETED
		MHL063-091	B. WING		08/	18/2021
	PROVIDER OR SUPPLIER	340 MIDE	DDRESS, CITY, DLETON STI S, NC 2732			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
V 121	This Rule is not me Based on record refailed to obtain drug one of three audited psychotropic drugs. Review on 8/18/21 c-Admission date of 6-Diagnoses of Mild I Syndrome, Hyperte Diabetes Mellitus, C Disease and Vitamir-There was no evide psychotropic medical Review of physician 8/17/21 revealed: -Order dated 10/7/21 (mg), Dissolve one obedtime Review of client #2 I Record (MAR) on 8/-August 2021- Client medication on 8/1 the July 2021- Client was medication on 7/1 the	et as evidenced by: view and interview, the facility reviews every six months for d clients (#2) who received The findings are: of client #2's record revealed: 6/1/11. ntellectual Disability, Down nsion, Hyperlipidemia, 6astroesophageal Reflux n D Deficiency. ence of a six-month ation review for client #2. orders for client #2 on 0 for Risperidone 3 milligram tablet on the tongue at Medication Administration 17/21 revealed: t was administered the above aru 8/16. as administered the above aru 7/31. vas administered the above	V 121	Page intentionally left blank		
	-She looked in client documentation from -She would contact t	ed: of what this entailed. chart and saw no the psychiatrist. he pharmacy. six-month psychotropic drug				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				3) DATE SURVEY COMPLETED	
MHL063-091			B. WING	B. WING			
	PROVIDER OR SUPPLIER TON STREET	340 MIDD	DRESS, CITY, LETON ST 5, NC 2732				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	JLD BE COMPLET		
	10A NCAC 27G .03 EXTERIOR REQUII (c) Each facility and maintained in a safe manner and shall be odor. This Rule is not me Based on observation failed to ensure facilin a safe, clean, attrikept free from offens Observation on 8/18 11:40am at the facilin-Hallway light had a -Client #2 bedroom scover was heavily did totes and personal if access if needed to -Hallway towards batelectrical socket cover a bin and And broken we exterior of the house -Outside office door of the light in the same and	its grounds shall be except free from offensive that as evidenced by: on and interview, the facility ity grounds were maintained active orderly manner and sive odor. The findings are: 8/21 at approximately the revealed the following: blown lightbulb. It is secolored and soiled; pillows, the secolored exists of the window exit due to fire. Confidence thair sitting by garbage walker leaning against the	V 736	-The Residential Team Leader had Hallway lightbulb replaced -Client # 2 was informed that staff w to assist her with cleaning her room including replacing her mattress coupillows and relocating the totes and personal items blocking her window provide her easy access to exit in cafire. The Residential Team Leader follow on Facility Work Orders to assure the complete - The missing electrical socket cover been replaced -Backyard- the black office chair and broken walker have been removed -Outside office door entrance - lights been replaced. The Residential Manager or designed ensure that the facility is maintained safe, clean and attractive manner and of offensive odor when completing the monthly environmental inspection. Worders will be completed immediated discovering an issue. The Residential Manager will provided Director of Program Operations montenvironmental Checklist for the next months.	rill need ver and to ase of a red up ey were r has I the oulb has e will in a d free ine Jork y after e the thly	10/19/2021	
	smelling of urineHe reminded client of her window.	daily to move items blocking e order is requested for					

PRINTED: 09/07/2021 **FORM APPROVED** Division of Health Service Regulation (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING: __ 08/18/2021 B. WING MHL063-091 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 340 MIDDLETON STREET **MIDDLETON STREET** ROBBINS, NC 27325 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) V 736 V 736 Continued From page 8 Page intentionally left blank house repairs, maintenance comes to address the identified issues. -Maintenance had been to the home to power wash and did not pick up the items on the back porch or replace lightbulbs. Interview on 8/18/21 with Qualified Professional revealed: -She confirmed there was a maintenance department that comes out to repair things in the -She thought maintenance had picked up the items on the back porch. -She confirmed facility staff failed to ensure facility grounds were maintained in a safe, clean, attractive, orderly manner and kept free from offensive odor.

PZU011





September 23, 2021

Tamara Gathers, Facility Compliance Consultant I Mental Health Licensure and Certification Section NC Division of Health Service Regulation 2718 Mail Service Center Raleigh, NC 27699-2718

RE: Green Street/Annual & Complaint/8-20-21 Middleton/Annual & Complaint/8-18-21 **DHSR** - Mental Health

SEP 29 2021

Lic. & Cert. Section

Hello,

Please find enclosed the Plan of Correction for deficiencies cited during the survey referenced above.

If you need additional information or have questions, please contact me directly at the number below.

Sincerely, Theresa Brochue

Theresa Brechue

Director of Regulatory Affairs

Theresa.Brechue@monarchnc.org

585 406-7440

