STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
,	0. 00.11.20.10.1		A. BUILDING:			
		MHL034-156	B. WING		R- 03/2	C 5/2022
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
HINKLE	HOUSE AT BETHABA	ARA	DE HAYES D I SALEM, NO			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
V 000	INITIAL COMMEN	 ГЅ	V 000			
	completed on Marc was substantiated.	ollow-Up Survey was th 25, 2022. The complaint (Intake #NC00186812 and eficiency was cited.				
	This facility is licens category:	sed for the following service				
		G .5600C: Supervised Living elopmental Disabilities				
		sed for 6 beds and currently The survey sample consisted mer client.				
V 291	27G .5603 Supervi	sed Living - Operations	V 291			
	six clients when the developmental disa on June 15, 2001, a than six clients at the provide services at licensed capacity. (b) Service Coordination of the service and iffied profession treatment/habilitation (c) Participation of Responsible Persoprovided the opportunity of the service of th	cility shall serve no more than e clients have mental illness or abilities. Any facility licensed and providing services to more nat time, may continue to no more than the facility's nation. Coordination shall be not the facility operator and the nals who are responsible for on or case management. The Family or Legally not be continued to maintain an ongoing or or his family through such				

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

TITLE (X6) DATE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COMPLETED		
			5 M/M/O		R-	
		MHL034-156	B. WING		03/2	5/2022
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
HINKLE	HOUSE AT BETHABA	·RΔ	DE HAYES D			
	T		SALEM, NO			
(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 SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	D BE	(X5) COMPLETE DATE
V 291	Continued From pa	ge 1	V 291			
	means as visits to the facility. Reports annually to the pare legally responsible. Reports may be in conference and shaprogress toward metal. (d) Program Activitiactivity opportunitieneeds and the treat Activities shall be dinclusion. Choices or legal system is in	he facility and visits outside is shall be submitted at least ent of a minor resident, or the person of an adult resident. Writing or take the form of a all focus on the client's eeting individual goals. ies. Each client shall have is based on her/his choices, ment/habilitation plan. esigned to foster community may be limited when the court involved or when health or me a primary concern.				
	staff failed to partici services, and maint with the client's fam	et as evidenced by: and record review, the facility pate in the coordination of ain an ongoing relationship illy or legally responsible mer client #1) of one client				
	record revealed: - admitted 10-1 - discharged 3 62 years old - diagnosed wit - Mild Ment Traumatic Brain Inju - Generaliz - Hypertens - Diabetes - High Bloo	22-22 h: al Retardation secondary to ury as a child ed Anxiety Disorder sion Mellitus II				

Division of Health Service Regulation

STATE FORM 6899 F2CC11 If continuation sheet 2 of 5

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		MHL034-156	B. WING		R-C 03/25/2022	
	PROVIDER OR SUPPLIER HOUSE AT BETHABA	2030 CLY	DDRESS, CITY, S 'DE HAYES D N SALEM, NO			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
V 291	- obesity - urinary ind Interview on 3-24-2	knee surgery, bilateral	V 291			
	- she was very up until she was ad October, 2018 - former client # Wednesday, 11-24 - "she was usin - "Then I notice	involved with former client #1 mitted to the facility in #1 came to stay with her #21 g a walker and doing okay" d her urine smelled strong and a UTI (urinary tract infection).				
	Sunday after Thank ordered an antibioti - while at the E pain, and an appoir orthopedic doctor o - her family too - former client a until 12-8-21, when	D, she complained of knee ntment was made to see an				
	having many health and more medical a - she returned t -21 - on 12-21-21, primary care physic doctor's visits while was not informed o	ient #1 getting older and issues, she has had more appointments and visits to the facility on Monday 12-20 facility staff took her to her cian to follow up on the she was at home, but she f that visit or the outcome.				
	worker from the do- would not have kno	ctor's office -otherwise she wn the facility took her almost never tell me about				

Division of Health Service Regulation STATE FORM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				3) DATE SURVEY COMPLETED	
		MUI 024 456	B. WING		R-C 03/25/2022		
		MHL034-156	B. WING		03/2	5/2022	
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
HINKLE	HOUSE AT BETHABA	ARA	DE HAYES D				
	OLIMA AA DV OTA		SALEM, NO			4.4-5	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE	
V 291	Continued From pa	ge 3	V 291				
	happening, since I of them." - "[Program Co several times, but of [former client #1] be	e texted, emailed or called, but					
	- S1 was not can doctor's visit for former clien called her family" - sometimes for sister after a doctor know what happened - when I did callenter a note in the esystem indicating the revery doctor's electronic document doctor seen and the	t #1 had a fall, "I always rmer client #1 would call her 's appointment, to let her ed I her sister, I didn't always electronic documentation ne call was made s visit was entered into the ntation system, including the e outcome or summary doctor's appointment, no," I					
	the Qualified Profes - she is only in with the facilty - "when a client fall or anything sign [electronic docume - several staff h so - "I don't know a and are now gone,	2, 3-23-22 and 3-25-22 with ssional (QP) revealed: her third week of employment goes to the doctor or has a ificant, we document that in a ntation program] note. have left during the last year or about the staff that were here but that's the expectation" do a search backwards in the					

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		MHL034-156	B. WING		R- 03/2	.C 2 5/2022
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
HINKLE	HOUSE AT BETHABA	RA	DE HAYES D SALEM, NO			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRODEFICIENCY)	JLD BE	(X5) COMPLETE DATE
V 291	staff documented c family after each m - "I don't see ar family, except the n messages, telephor notifying the family "A lot of these honest with you -wir turnover, I don't see of each visit." - "We documen note indicating family dropped the ball." - reported since going forward, family	atation program to determine if contacting former client #1's edical appointment. By that they contacted the otes I wrote. Nothing like text one calls, or emails about " got dropped, I'm just being the staff leaving and staff e where we notified the family of the text of the weak of the staff leaving and staff e where we notified the family of the staff leaving and staff e where we notified. They just the she has been the QP, and ly members have been ignificant event including all	V 291			

6899

Division of Health Service Regulation STATE FORM

F2CC11 If continuation sheet 5 of 5