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SHARPE AND WILLIAMS #2	4408 NORTHAMPTON DRIVE WINSTON-SALEM, NC 27105

(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 A follow up survey was completed on June 8, 2022. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600A Supervised Living for Adults with Mental Illness. This facility is licensed for 6 and currently has a census of 3. The survey sample consisted of audits of 3 current clients.	{V 000}		
{V 109}	27G .0203 Privileging/Training Professionals 10A NCAC 27G .0203 COMPETENCIES OF QUALIFIED PROFESSIONALS AND ASSOCIATE PROFESSIONALS (a) There shall be no privileging requirements for qualified professionals or associate professionals. (b) Qualified professionals and associate professionals shall demonstrate knowledge, skills and abilities required by the population served. (c) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence. (d) 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. (e) Qualified professionals as specified in 10A NCAC 27G .0104 (18)(a) are deemed to have met the requirements of the competency-based employment system in the State Plan for MH/DD/SAS.	{V 109}		

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{V 109}	Continued From page 1 (f) The governing body for each facility shall develop and implement policies and procedures for the initiation of an individualized supervision plan upon hiring each associate professional. (g) The associate professional shall be supervised by a qualified professional with the population served for the period of time as specified in Rule .0104 of this Subchapter. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, 2 of 2 Qualified Professionals ((QP#1) and Qualified Professional #2/Chief Executive Officer/Licensee/Registered Nurse (QP#2/CEO/L/RN)) failed to demonstrate the knowledge, skills and abilities required by the population served. The findings are: Review on 5/23/22 of the QP #1's record revealed: -A hire date of 3/29/18 -A job description of QP Review on 5/23/22 of the QP #2/CEO/L/RN's record revealed: -A hire date of 3/20/09 -A job description of CEO -A degree and work history that qualified her as a QP Finding #1 Refer to tag V112 for evidence of client #3's treatment plan not addressing his foot care issues.	{V 109}		

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{V 109}	Continued From page 2 Review on 5/23/22 of client #3's record revealed: -An admission date of 1/17/19 -Diagnoses of Schizoaffective Disorder, Borderline Intellectual Functioning, Acne and Multiple Environmental Allergies -The treatment plan was dated 3/25/22 and then revised on 5/3/22 by the QP #1 -No goals or strategies in client #3's treatment plan to specifically address issues related to foot care or his refusal to see a podiatrist. Interview on 6/7/22 with the QP #1 revealed: -Had forgotten to add goals and strategies to client #3's treatment plan for foot care -"I wasn't even thinking about putting it in there because he just refuses to go ...I can put it in his treatment plan today (6/7/22) ..." Finding #2 Refer to V291 for evidence of failure to coordinate care with a podiatrist for overgrown nails. Finding #3 Refer to V736 for evidence that the QP#2/CEO/L/RN was aware of environmental and physical plant issues within the facility and had not corrected them. Observations on 5/23/22 from 2:20pm to 3:01pm of the facility and its grounds revealed: -Physical plant and environmental issues were not corrected and additional deficiencies were identified during the walk through of the facility Interview on 6/7/22 with the QP #1 revealed: -When asked about other repairs not completed, the QP #1 stated this was a question the QP #2/L/CEO/RN would need to answer	{V 109}		

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{V 109}	Continued From page 3 Attempted interviews on 6/7/22 and 6/8/22 with the QP #2/CEO/L/RN were not successful as telephone calls were not returned. This deficiency is cross referenced into 10A NCAC 27G .5601 Scope (V289) for a Continued Failure to Correct Type A1.	{V 109}		
{V 112}	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.	{V 112}		

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{V 112}	Continued From page 4 This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to develop and implement goals and strategies to meet the individualized needs for 1 of 3 clients (#3). The findings are: Review on 5/23/22 of client #3's treatment plan revealed: -An updated treatment plan dated on 5/3/22 noted client #3 would work on his hygiene daily -No goals or strategies in client #3's treatment plan to specifically address issues related to foot care or his refusal to see a podiatrist Observation and interview on 5/23/22 at approximately 3:32pm with client #3 revealed: -Both of client #3's great toenails were thick and had ridges -They had grown over the top of the nail bed, one at an angle and one with cracks -Client #3 stated "I am not going to the doctor's office to get my toenails cut ..." Interview on 6/7/22 with client #3's guardian of the person revealed: -Had signed off on client #3's treatment plan -There was no specific goal related to client #3's issues with his feet or toenails. -The QP #1 had not mentioned any problems with client #3's feet or toenails. Interview on 6/7/22 with the QP #1 revealed: -Had forgotten to add goals and strategies to client #3's treatment plan for foot care -"I wasn't even thinking about putting it in there	{V 112}		

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{V 112}	Continued From page 5 because he just refuses to go ...I can put it in his treatment plan today (6/7/22) ..." This deficiency is cross referenced into 10A NCAC 27G .5601 Scope (V289) for a Continued Failure to Correct Type A1.	{V 112}		
{V 289}	27G .5601 Supervised Living - Scope 10A NCAC 27G .5601 SCOPE (a) Supervised living is a 24-hour facility which provides residential services to individuals in a home environment where the primary purpose of these services is the care, habilitation or rehabilitation of individuals who have a mental illness, a developmental disability or disabilities, or a substance abuse disorder, and who require supervision when in the residence. (b) A supervised living facility shall be licensed if the facility serves either: (1) one or more minor clients; or (2) two or more adult clients. Minor and adult clients shall not reside in the same facility. (c) Each supervised living facility shall be licensed to serve a specific population as designated below: (1) "A" designation means a facility which serves adults whose primary diagnosis is mental illness but may also have other diagnoses; (2) "B" designation means a facility which serves minors whose primary diagnosis is a developmental disability but may also have other diagnoses; (3) "C" designation means a facility which serves adults whose primary diagnosis is a developmental disability but may also have other diagnoses; (4) "D" designation means a facility which	{V 289}		

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{V 289}	Continued From page 6 serves minors whose primary diagnosis is substance abuse dependency but may also have other diagnoses; (5) "E" designation means a facility which serves adults whose primary diagnosis is substance abuse dependency but may also have other diagnoses; or (6) "F" designation means a facility in a private residence, which serves no more than three adult clients whose primary diagnoses is mental illness but may also have other disabilities, or three adult clients or three minor clients whose primary diagnoses is developmental disabilities but may also have other disabilities who live with a family and the family provides the service. This facility shall be exempt from the following rules: 10A NCAC 27G .0201 (a)(1),(2),(3),(4),(5)(A)&(B); (6); (7)(A),(B),(E),(F),(G),(H); (8); (11); (13); (15); (16); (18) and (b); 10A NCAC 27G .0202(a),(d),(g)(1)(i); 10A NCAC 27G .0203; 10A NCAC 27G .0205 (a),(b); 10A NCAC 27G .0207 (b),(c); 10A NCAC 27G .0208 (b),(e); 10A NCAC 27G .0209[(c)(1) - non-prescription medications only] (d)(2),(4); (e)(1)(A),(D),(E);(f);(g); and 10A NCAC 27G .0304 (b)(2),(d)(4). This facility shall also be known as alternative family living or assisted family living (AFL). This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to assure that residential services were provided to individuals in a home environment where the primary purpose of these services is the care, habilitation or rehabilitation of individuals who have a	{V 289}		

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{V 289}	Continued From page 7 developmental disability or disabilities, and who require supervision when in the residence affecting 3 of 3 clients (#1, #2 and #3). The findings are: Cross Reference: 10A NCAC 27G .0203 Competencies of Qualified Professionals and Associate Professionals (V109). Based on observations, record reviews and interviews, 2 of 2 Qualified Professionals ((QP#1) and Qualified Professional #2/Chief Executive Officer/Licensee/Registered Nurse (QP#2/CEO/L/RN)) failed to demonstrate the knowledge, skills and abilities required by the population served. Cross Reference: 10A NCAC 27G .0205 Assessment and Treatment/Habilitation or Service Plan (V112). Based on observations, record reviews and interviews, the facility failed to develop and implement goals and strategies to meet the individualized needs for 1 of 3 clients (#3). Cross Reference: 10A NCAC 27G .5603 Operations (V291). Based on observations, record reviews and interviews, the facility failed to coordinate care for 1 of 3 clients (#3). Cross Reference: General Statute 122C-62 Smoking Prohibited (V369). Based on observations, record reviews and interviews, the facility staff failed to prohibit smoking inside the facility. Cross References: 10A NCAC 27G .0303 Location and Exterior Requirements (V736). Based on observations, record reviews and interviews, the facility was not maintained in a safe, clean, attractive, and orderly manner.	{V 289}		

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{V 289}	Continued From page 8 Review on 6/8/22 of the facility's Plan of Protection dated 6/8/22 and written by the QP #1 revealed: -"What immediate action will the facility take to ensure the safety of the consumers in your care? We will continue to immediately (6/8/2022) work with [a maintenance company] and an in-house [maintenance man] on the repairs of the home. We will continue to immediately (6/8/2022) address the smoking policy in the homes. We will continue to immediately (6/8/2022) make sure the exterior of the home is clean and free of debris and tree limbs. -Describe your plans to make sure the above happens. The QP (#1) and Administrative assistant will continue to work with [a maintenance company] and the in-house [maintenance man], on the repairs of the home. The QP (#1) does not agree with the coordination with guardian deficiency. The QP (#1) has coordinated with the guardian the care of the resident by a telephone call. The QP (#1) ensure that each guardian is informed of their person." The facility was licensed as a Supervised Living for Adults with Mental Illness and served 3 adult males who had diagnoses that included Schizoaffective Disorder, Bipolar Disorder, Borderline Intellectual Functioning and Paranoid Schizophrenia. Client #3's treatment plan was revised on May 3, 2022 by the QP #1 and failed to develop and implement goals and strategies to identify client #3's specific needs for toenail care and refusal to see a podiatrist. Client #3's top toenails were thick, had ridges and had grown over the nail bed. The other toenails were cut but not filed. The QP #1 failed to notify and coordinate with client #3's guardian of the person to address his need to see a podiatrist. Client #3	{V 289}		

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{V 289}	Continued From page 9 smoked in the facility, as evidenced by having a container with smoked cigarette butts and ashes in his bedroom, even though the no smoking policy had been reviewed with him. The QP #1 and the QP#2/CEO/L/RN were not aware client #3 continued to smoke in the facility as previously cited. The facility's physical plant and environmental issues had been cited six different times since 11/15/2019. The QP#2/CEO/L/RN failed to address the previously cited issues, with new additional issues such as the grass in the front and back yard of the facility was approximately 2 feet high, the old shower floor, cardboard boxes, trash bags and metal drain pipes were stacked outside on the left side of the facility and the back deck was slippery due to a green like substance on the floor boards. This deficiency constitutes a Continued Failure to Correct Type A1 rule violation originally cited for serious neglect. An administrative penalty of $500.00 per day continues to be imposed for failure to correct within 23 days.	{V 289}		
{V 291}	27G .5603 Supervised Living - Operations 10A NCAC 27G .5603 OPERATIONS (a) Capacity. A facility shall serve no more than six clients when the clients have mental illness or developmental disabilities. Any facility licensed on June 15, 2001, and providing services to more than six clients at that time, may continue to provide services at no more than the facility's licensed capacity. (b) Service Coordination. Coordination shall be maintained between the facility operator and the qualified professionals who are responsible for treatment/habilitation or case management. (c) Participation of the Family or Legally	{V 291}		

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{V 291}	Continued From page 10 Responsible Person. Each client shall be provided the opportunity to maintain an ongoing relationship with her or his family through such means as visits to the facility and visits outside the facility. Reports shall be submitted at least annually to the parent of a minor resident, or the legally responsible person of an adult resident. Reports may be in writing or take the form of a conference and shall focus on the client's progress toward meeting individual goals. (d) Program Activities. Each client shall have activity opportunities based on her/his choices, needs and the treatment/habilitation plan. Activities shall be designed to foster community inclusion. Choices may be limited when the court or legal system is involved or when health or safety issues become a primary concern. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to coordinate care for 1 of 3 clients (#3). The findings are: Observation and interview on 5/23/22 at approximately 3:32pm with client #3 revealed: -On client #3's left foot the great toenail appeared to go over the top of the great toe, curling over and under it, -The nail bed appeared to be thick and with ridges -The nail growth is at an angle over the great toe. -On client #3's right foot the great toenail comes up off of the nail bed. -The nail bed appeared to be thick and with ridges -The nail growth appeared to go off the end of the toe -The nail had cracks, ridges and thickening.	{V 291}		

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{V 291}	Continued From page 11 -The remainder of client #3's other toenails on both feet were newly cut and not filed. -"I am not going to the doctor's office to get my toenails cut. [Client #1] tried to trim my nails, but his clippers were too small. We need the really big ones (nail clippers)." Interview on 5/23/22 with staff #1 revealed: -People (medical professionals) came to the facility to cut client #3's toenails but he refused -"I tried to cut his toenails with my clippers (nail), but could not do it ...the toenails were too thick..." Interview on 6/6/22 with client #3's former guardian of the person revealed: -Had worked with him for several months and his case was recently transferred to another worker in the department -Their agency is "guardian of the person" for client #3 -No facility staff had ever contacted her about client #3's need to see a podiatrist due to the condition of his toenails on both feet. -Client #3 had a lot of paranoia of medical appointments, which included giving blood and receiving shots. -Her Agency would be more than happy to assist with getting client #3 to the podiatrist. Interview on 6/7/22 with client #3's current guardian of the person revealed: -Had been client #3's guardian of the person for 2 months now -Had been made aware of client #3's refusal to attend medical appointments, but nothing specifically related to nail care or podiatry appointments. -Had visited with client #3 on 5/23/22 and no facility staff had made him aware of the condition of the toenails on his feet, including Qualified	{V 291}		

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{V 291}	Continued From page 12 Professional #1 (QP #1) -Was not aware of client #3's upcoming podiatry appointment on 7/20/22 -Would be glad to assist in getting client #3 to his upcoming appointment -"With [client #3], staff needed to work with him every step of the way to ensure his needs were met ..." -"Any voicemail messages our agency receives are forwarded to our email." -Reviewed his documentation and had no contact with QP #1 regarding missed or future appointments for client #3. -Also reviewed his emails and there was no information QP #1 had contacted him regarding client #3's medical visits Interview on 5/26/2022 with the QP #1 revealed: -Was responsible for ensuring client #3 attended all of his appointments, including ones with the podiatrist. -Client #3 was last seen by the podiatrist on 7/17/21 -Client #3 refused to be transported by the Medicaid van to his scheduled podiatrist appointment on 5/10/22 -Had notified client #3's guardian of the person about his refusal to attend his scheduled appointment (on 5/10/22) -The QP #1 was currently following up with podiatry services that can come to the facility -Client #3's next podiatry appointment was scheduled for 7/20/22 at 4pm Further interview on 6/7/22 with the QP #1 revealed: -The facility used to have a podiatrist come to the facility every 3 months for foot care for the clients. -"We have not had a podiatrist come out since the pandemic (COVID-19). Right now, we are just	{V 291}		

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(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 291}	Continued From page 13 trying to work on [client #3]'s anxiety about medical appointments." -Had not had a lot of contact with client #3's former guardian of the person -"I did not speak with her that often. The last time I spoke with her was when [client #3] had to go to the hospital due to Jaundice (on 5/23/22) ... I have noticed that he (client #3) has a limp when he walks and has problems with ambulation ..." -Regarding contact with client #3"s new guardian, "I had not spoken to him until the day [client #3] was hospitalized ...he (the new guardian of the person) may not remember that I told him about issues with getting [client #3] to the podiatrist, as there was a lot going on that day (5/23/22). I know I told him about it ..." -Had not shared with the new guardian of the person, client #3's upcoming podiatrist appointment scheduled for July 20th (2022). Attempted interviews on 6/7/22 and 6/8/22 with the QP #2/CEO/L/RN were not successful as telephone calls were not returned. This deficiency is cross referenced into 10A NCAC 27G .5601 Scope (V289) for a Continued Failure to Correct Type A1.	{V 291}		
{V 369}	G.S. 122C-6 Smoking Prohibited § 122C-6 SMOKING PROHIBITED; PENALTY (a) Smoking is prohibited inside facilities licensed under this Chapter. As used in this section, "smoking" means the use or possession of any lighted cigar, cigarette, pipe, or other lighted smoking product. As used in this section, "inside" means a fully enclosed area. (b) The person who owns, manages, operates, or otherwise controls a facility subject to this section	{V 369}		

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	MHL034-303	A. BUILDING: _____ B. WING _____	R 06/08/2022

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{V 369}	Continued From page 14 shall: (1) Conspicuously post signs clearly stating that smoking is prohibited inside the facility. The signs may include the international "No Smoking" symbol, which consists of a pictorial representation of a burning cigarette enclosed in a red circle with a red bar across it. (2) Direct any person who is smoking inside the facility to extinguish the lighted smoking product. (3) Provide written notice to individuals upon admittance that smoking is prohibited inside the facility and obtain the signature of the individual or the individual's representative acknowledging receipt of the notice. (c) The Department may impose an administrative penalty not to exceed two hundred dollars ($200.00) for each violation on any person who owns, manages, operates, or otherwise controls a facility licensed under this Chapter and fails to comply with subsection (b) of this section. A violation of this section constitutes a civil offense only and is not a crime. (d) This section does not apply to State psychiatric hospitals. (2007-459, s. 3.) This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the staff failed to prohibit smoking inside the facility. The findings are: Observations on 5/23/22 at approximately 3:01pm of client #3's bedroom revealed: -A strong smell of cigarette smoke -In client #3's bedroom was a red plastic cup which contained multiple smoked cigarette butts and ashes on top of the dresser	{V 369}		

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{V 369}	Continued From page 15 Observation and interview on 5/6/22 at approximately 3:03pm with client #3 revealed: -"You know what I have been doing (grinned)..." in relation to cigarette butts and ashes in the red plastic cup on his dresser Interview on 5/6/22 with staff #1 revealed: -Was not sure why there were cigarette butts and ashes in a cup in client #3's bedroom -"Apparently he has been smoking in the facility and I did not know about it ..." Interview on 6/7/22 with client #3's guardian of the person revealed: -Had not been informed by any facility staff client #3 had been smoking inside the facility -Felt it was a fire hazard and not safe for the clients or staff in the facility Interview on 6/7/22 with the QP #1 revealed: -Was not aware client #3 was smoking in his bedroom -"The only thing I see is him smoking outside or rolling his own cigarettes. I have not had to fine him for smoking in the facility ..." Attempted interviews on 6/7/22 and 6/8/22 with the QP #2/CEO/L/RN were not successful as telephone calls were not returned. This deficiency is cross referenced into 10A NCAC 27G .5601 Scope (V289) for a Continued Failure to Correct Type A1.	{V 369}		
{V 736}	27G .0303(c) Facility and Grounds Maintenance 10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS	{V 736}		

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{V 736}	Continued From page 16 (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. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility was not maintained in a safe, clean, attractive and orderly manner. The findings are: Finding #1 Previously cited physical plant issues, during the 4/8/22 survey, that had not been corrected are listed below. Observations on 5/23/22 from approximately 2:20pm to 3:03pm of the inside and outside of the facility revealed: -A green like substance was growing on the wall behind the a/c unit -The glass door to the facility had cardboard wedged in between the frame and the glass -Smoke detectors were continuously beeping in both the living room and in client #2's bedroom -The ceiling air vent was covered in dust -All of the wooden flooring in the living room was scratched, scuffed and stained. -Debris (leaves and cobwebs) in two of the facility's outside windows sills -A strong smell of cigarette smoke was in client #3's bedroom. -More of client #3's clothing was piled up in front of his closet and a white tape like substance partial covered a hole in his closet door -Former Client #4 (FC #4)'s bedroom had a metal	{V 736}		

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{V 736}	Continued From page 17 bedframe that stuck out approximately 4 inches from the mattress -Repairs had started to the steps leading down to FC #5's bedroom, but no new carpet was in place. -Fallen tree limbs in the backyard -In one of the client's bathrooms was a broken towel rack attached to the wall -In all of the clients' bedrooms, the carpet was stained in multiple places -In the second clients' bathroom, a 3 x 3 square tile was not flush with the ceiling and frame -Also, in this bathroom was a broken, rusted towel bracket and a burned-out light bulb over the vanity's mirror -In the kitchen area, there were no chairs for the clients to sit at the table for their meals, dirty dishes were stacked in the double sink and the dishwasher was broken. Finding #2 New physical plant and environmental issues identified during this survey are listed below. Observations on 5/23/22 from approximately 2:20pm to 3:03pm of the inside and outside of the facility revealed: -Numerous crumpled paper towels/napkins littered the front and back of the facility -The grass in the front and back of the facility was approximately 2 feet tall -Numerous cigarette butts littered the front yard in front of the facility's ramp and around the facility's grounds -The front door's oval glass window had separated from the wooden door -On the left side of the facility, numerous items were stacked up which included the old shower floor, which was filled with brown colored water, wet cardboard boxes, two large trash bags filled	{V 736}		

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{V 736}	Continued From page 18 with debris, wet leaves, and metal drainpipes -A broken gray bucket filled with dead leaves on the side of the facility -A black plastic crate with debris inside it -A 3 feet long detached black plastic drainpipe next to the facility's side yard -Another 3 feet long detached black plastic drainpipe was lying in the middle of the back yard -Behind the air conditioner (a/c)'s unit was a green metal shower head -Two empty soda bottles and an empty pack of cigarettes were on the ground near the facility's back deck -The back deck was slippery due to a green like substance on the floorboards -A green like substance was on all the railings of the deck -An empty black plastic lining of a flowerpot was lying on its side on the deck -A collapsible black plastic crate was on the deck next to the back door -On the right side of the facility was a blue bucket lying on its side -Part of a metal gutter hung down and was separated from the facility's gutter - In client #2's bedroom, the ceiling fan had approximately an inch of dust on all of the blades and an exposed wire was on the left side of the base board -In client #3's bedroom was a red plastic cup which contained multiple smoked cigarette butts and ashes on top of the dresser -In client #3's bedroom, dirty clothes were on the floor, balled up paper towels littered part of his floor and an aqua colored blanket partially covered the items -A fitted red bedsheet was partial pulled off client #3's mattress and exposed a soiled mattress -No curtains or blinds were on the window in FC #5's room	{V 736}		

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{V 736}	Continued From page 19 -FC #5's bed had stained pillows with no pillow covers on the bed and the bottom door of his dresser would not close properly Review on 6/7/22 of a receipt dated 5/13/22 for repairs to the facility revealed: -Invoice # 000706 -"1) Remove existing shower, 2) Repair sub floor, 3) Reinstall new shower pan, glass enclosure, shower walls, 4) At this point, I'll assume no flooring will need to be done but depending on the shape of the new base we may need to redo the flooring, 5) Reuse the current shower head and faucet, 6) Remove existing flooring (laminate). It wasn't in good shape to begin with although you could have gotten away with leaving it if not for the sub floor issues. Due to the subfloor issues it needed to be removed and replaced, 7) Remove and replace entire subfloor in bath and reinstall new treated ¾-inch plywood (repaired some floor joists), 8) Install new flooring (LVP), 9) We had to replace the shower faucet due to some plumbing changes that were needed. Materials 1.0 $1,700.00 $1,700.00 ..." -The total for these repairs were $3,104.00 Interviews on 5/6/22 with clients #1 and #3 revealed: -Only some of the repairs to the facility had been made. -Neither client would expand on this statement -Client #3 stated the grass needed to be cut as "it is too long, and it has been a long time since it has been mowed ..." Interview on 5/23/22 with the Assistant Qualified Professional (AQP) revealed: -The grass gets mowed every two weeks. -"When the rain stops, they will be out to mow the	{V 736}		

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{V 736}	Continued From page 20 lawn." -Asked if he should join the surveyor to walk around the facility. -"I don't want to walk in all that high grass (approximately 2 feet high)." -The debris on the left side of the facility was from when the shower was repaired on 5/20/22. -"We will get someone out tomorrow to remove all of it." Interview on 6/7/22 with the Qualified Professional #1 revealed: -"We did the repairs on our own. The yard was mowed by a family friend ..." -Due to all the rain, the grass was not cut until recently (no date given) ..." -Was not sure why the maintenance man did not clean up after he repaired the shower. -"He should not have left all that stuff (debris) on the side of the house. I do know he came out the next day after your visit ..." -The Qualified Professional #2/Chief Executive Officer/Licensee/Registered Nurse (QP#2/CEO/L/RN) would need to answer questions about the other repairs not being completed -"We do have the bench in the dining area where all three of the clients can sit together for meals ...they (the clients) are not big at all and can all fit on it (the bench) ..." Attempted interviews on 6/7/22 and 6/8/22 with the QP #2/CEO/L/RN were not successful as telephone calls were not returned. This deficiency is cross referenced into 10A NCAC 27G .5601 Scope (V289) for a Continued Failure to Correct Type A1.	{V 736}		