

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL034-342</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/27/2022</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>BOTTOM UP OUTREACH CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>554 BEDFORD KNOLL DRIVE WINSTON SALEM, NC 27107</b>
--	---

(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	<p><b>INITIAL COMMENTS</b></p> <p>A complaint survey was completed on June 27, 2022. The complaint was unsubstantiated (Intake #NC00190087). A deficiency was cited.</p> <p>This facility is licensed for the following category: 10A NCAC 27G. 5600 C Supervised Living for Adults with Developmental Disabilities.</p> <p>This facility is licensed for 3 and currently has a census of 3. The survey sample consisted of audits of 3 current clients.</p>	V 000		
V 291	<p><b>27G .5603 Supervised Living - Operations</b></p> <p>10A NCAC 27G .5603 OPERATIONS</p> <p>(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.</p> <p>(b) Service Coordination. Coordination shall be maintained between the facility operator and the qualified professionals who are responsible for treatment/habilitation or case management.</p> <p>(c) Participation of the Family or Legally 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.</p> <p>(d) Program Activities. Each client shall have activity opportunities based on her/his choices,</p>	V 291		

Division of Health Service Regulation LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
--	-------	-----------

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL034-342</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/27/2022</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>BOTTOM UP OUTREACH CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>554 BEDFORD KNOLL DRIVE WINSTON SALEM, NC 27107</b>
--	---

(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	<p>Continued From page 1</p> <p>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.</p> <p>This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to coordinate medical care and failed to maintain contact with the legally responsible person of an adult resident affecting 1 of 3 clients (#1). The findings are:</p> <p>Review on 6/17/22 of client #1's record revealed: -An admission date of 4/30/22 -Diagnoses of Generalized Anxiety Disorder; Autism Spectrum Disorder; Mild Intellectual Disabilities; Seizure Disorder; Bipolar I Disorder; Borderline Personality Traits; Intermittent Explosive Disorder by history; Major Neurocognitive Disorder due to TBI (traumatic brain injury), and Tobacco Use Disorder -Date of Assessment: 8/27/2021 noted "struggles with expressing his anger appropriately. He receives supports with increasing adaptive coping skills and managing his anger and impulsive behaviors. Guardian reports a history of multiple diagnoses including birth complications fetal distress reportedly caused brain damage, history of Mild IDD, Autism, and explosive anger, had a TBI/head injury at 5.5 years (fell out the window from 2 stories), Medical: Reported history of Mild MR, explosive personality disorder, high risk sexual behavior, and organic brain syndrome, seizure disorder, PDD, Autism, head injury age 5 and depression, Discharged from his recent AFL placement due to extreme behaviors, In the past, I have been known to elope with strangers and</p>	V 291		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL034-342</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/27/2022</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>BOTTOM UP OUTREACH CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>554 BEDFORD KNOLL DRIVE WINSTON SALEM, NC 27107</b>
--	---

(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	<p>Continued From page 2</p> <p>sexual predators therefore; require 24-hour supports ...has not had a seizure in a long time, Depakote levels must be tested regularly and was previously in an AFL (Alternative Family Living group home with the [Chief Executive Officer (CEO)."</p> <p>-A treatment plan dated 5/1/2022 noted "Behavioral Health needs: prevention of assaults or injuries to others i.e. hitting, punching, prevention of suicide attempts; has made threats to harm himself in the past, tantrums or emotional outbursts, exposes his stomach and top of his butt in home and community, has a tendency to lie and manipulate situations/people to get his way, is to be monitored/supervised at all times, including when he is using computer and Phone, has a history and will use the internet, Facebook Messenger, and telephone too, will seek relationships with strangers that include sex, should not be left alone with minors, needs to be healthy and safe, improve adaptive functioning skills, develop and use coping skills, - attend all doctor's appointments, be active in his community, increase prosocial skills as he decreases maladaptive behaviors and participate in activities at YMCA (Young Men's Christian Association)."</p> <p>Observations and interviews on 6/17/22 at 8:12am with client #1 revealed: -No injuries or bruises noted on his person -Had been punched in the eye by client #2 -Had a black eye after client #2 "jumped on me and hit me two times ..." -Had refused to go back to the hospital on 5/24/22 -"I had gotten out of the hospital on 5/24/22 and I was not going back. [The QP] told me to put ice on my eye, so that is what I did ...I was not worried about my black eyes ..."</p>	V 291		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL034-342</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/27/2022</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>BOTTOM UP OUTREACH CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>554 BEDFORD KNOLL DRIVE WINSTON SALEM, NC 27107</b>
--	---

(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	<p>Continued From page 3</p> <p>Review on 6/23/22 of client #1's after summary hospital records revealed:                      -Client #1 was seen on 5/23/22 at a local hospital's emergency room                      -This emergency room visit "was due to self-injurious behaviors at the day program at a church."                      -Reason for visit: assault victim                      -Diagnosis: Encounter for Medical Screening Examination                      -No medications were prescribed                      -No upcoming appointments were ordered.                      -Client #1 was discharged on 5/24/22 at 3:17pm                      -No documentation client #1 was seen by a medical professional after he was punched in the eye on 5/24/22 after returning to the facility after being discharged</p> <p>Interview on 6/17/22 with client #1's legal guardian revealed: on 6/17/22 revealed:                      -Client #1 was not seen by a medical professional after suffering a black eye                      -"I only found out about his black eye when the hospital called me ..."                      -The legal guardian was not contacted about client #1's injury until several days later                      -Had requested photographs of client #1's injury                      -Had never received the requested photographs</p> <p>Interview on 6/27/22 with the Adult Protective Services Social Worker revealed:                      -Had observed client #1 with black eyes                      -"It appeared as if there might have been a clot ...I asked if he was seen by a doctor and [the QP] told me know ...I saw [client #1] a few days later and his eye had healed ...I asked [the QP] if he had contacted [client #1]'s legal guardian and he stated he had not contacted him right away, but several days later ..."</p>	V 291		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL034-342</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/27/2022</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>BOTTOM UP OUTREACH CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>554 BEDFORD KNOLL DRIVE WINSTON SALEM, NC 27107</b>
--	---

(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	<p>Continued From page 4</p> <p>-The police have closed their case because it was assault by another resident</p> <p>Interview on 6/21/22 with the responding deputy to a 911 call revealed: -Responded on 5/27/22 to a company in response to an assault -Was adamant the call came in on 5/27/22 and not an earlier date -"[Client #1] ran from a school setting and stated he was assaulted. The call was transferred to our Agency as it was in the county's jurisdiction and not the city's. [Client #1] had gotten mad over a cigarette and had pushed a female staff. He ran off towards a business. I did see some scrapes on his knees and his black eye ..." -EMS was not called to assess client #1's injuries</p> <p>Interviews on 6/17/22 , 6/23/22 and 6/27/22 with the QP revealed: -Client #1 when he returned back to the facility from the hospital on 5/24/22, that is when [client #2] hit him and he got a black eye ..." -Had asked client #1 if he wanted to go to the doctor to have his black eye checked out on several occasions -Client #1 stated he was not going to go to the doctor -Had not notified client #1's legal guardian about the injury until several days later. -Had not called Emergency Medical Services (EMS) to assess client #1's injury -In the future, he would seek medical help for any injuries to the clients, including either an EMS assessment or a medical assessment at the hospital</p> <p>Interviews on 6/23/22 and 6/27/22 with the CEO revealed: -Client #1 had a black eye after being hit by client</p>	V 291		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL034-342</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/27/2022</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>BOTTOM UP OUTREACH CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>554 BEDFORD KNOLL DRIVE WINSTON SALEM, NC 27107</b>
--	---

(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 5  #2 -"His eye, underneath, was black and I did not see any swelling ...when I saw him a few days later, the bruising was gone ...was not sure if the QP had him seen at the hospital, but I know he iced his eye ...I was not aware [the QP] had not contacted [client #1]'s father right away ...that is our policy ..."	V 291		