STATEMEN	of Health Service Re IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
AND PLAN	OF CORRECTION	A.				
		MHL032-498	B. WING			R 24/2022
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
MELODY	HOUSE#1, LLC		DARWOOD DR /I, NC 27707	IVE		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF		(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	COMPLET
V 000	INITIAL COMMENT	ſS	V 000			
		w up survey was completed . Deficiencies were cited.				
	category: 10A NCA	sed for the following service C 27G .5600C Supervised h Developmental Disability.				
	census of 4. The su	sed for 6 and currently has a urvey sample consisted of clients and 1 former client.				
V 108	27G .0202 (F-I) Per	rsonnel Requirements	V 108			
	 (g) Employee train provided and, at a r following: (1) general organiz (2) training on clier delineated in 10A N 10A NCAC 26B; (3) training to mee client as specified in plan; and (4) training in infect bloodborne pathoge (h) Except as perm .5602(b) of this Sub member shall be av times when a client 	cation shall be documented. ing programs shall be minimum, shall consist of the cational orientation; nt rights and confidentiality as ICAC 27C, 27D, 27E, 27F and t the mh/dd/sa needs of the n the treatment/habilitation tious diseases and				
	including seizure m to provide cardiopu trained in the Heim techniques such as the American Heart	anagement, currently trained Imonary resuscitation and lich maneuver or other first aid those provided by Red Cross Association or their eving airway obstruction.				

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

TITLE

(X6) DATE

	of Health Service Re				[
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		MHL032-498	B. WING			R 24/2022
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
		3116 CEI		RIVE		
MELODY	(HOUSE#1, LLC	DURHAN	I, NC 27707			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	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) COMPLET DATE
V 108	Continued From pa	qe 1	V 108			
	 (i) The governing b implement policies reporting, investigat 	ody shall develop and and procedures for identifying, ting and controlling infectious diseases of personnel and				
	facility failed to ensu (#1 and #2) had tra Resuscitation (CPR (#2) had training in audited staff (#1, #2 had training to mee developmental disa	et as evidenced by: views and interviews, the ure two of four audited staff ining in Cardiopulmonary R); one of four audited staff First Aid (FA) and three of four 2 and Program Coordinator) t the mental health and bility needs of the clients as itment/habilitation plan. The				
	revealed: -Admission date of -Diagnoses of Schiz Hypersalivation, Tao Diabetes Insipidus,	22 of client #1's record 2/14/19. zoaffective Disorder, chycardia, Nephrogenic Osteopenia, Overweight, y, Hyperlipidemia and Tinea				
	revealed: -Admission date of -Diagnoses of Schiz Type, Obesity, Coca Use Disorder and T	22 of client #2's record 8/11/22. zoaffective Disorder-Bipolar aine Use Disorder, Cannabis Type II Diabetes, History of ad Vitamin D Deficiency.				

Bit PLAN COP CORRECTION AND PLAN COP CORRECTION (X1) PREVINCE LENCLA DENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A BUILDING: (X2) DATE SURVEY A BUILDING: NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITV. STATE; 2P CODE Recommendation MELODY HOUSE#1, LLC STREET ADDRESS, CITV. STATE; 2P CODE Bit CEDARWCOD DRIVE DURHAM, NC 27707 MELODY HOUSE#1, LLC SUMMARY STATEMENT OF DEPICIENCIES (EACH DEPICENCY WIST BE PRECEDED BY PLUL TAG PREVIDENCE V108 Continued From page 2 V108 CROSS-REFRENCED TO THE APPROPRIATE DEFICIENCY V 108 Continued From page 2 V108 V108 0. Review on 8/22/22 of client #3's record revealed: -Admission date of 7/29/19. -Diagnoses of Schizoaffective Disorder-Bipolar type, Hypertension, Coronary Artery Disease, Type II Disbetes, Nonrheumatic Aortic Valve Insufficiency and Normic Obstructive Pulmonary Disease and Tobacco Use Disorder. -Diagnoses of Schizoaffective Planonary Disease and Tobacco Use Disorder. -Diagnoses of Schizoaffective Planonary Disease and Tobacco Use Disorder. -Discharge date of 8/16/22. Review on 8/22/22 of Ct #5's record revealed: -Admission date of 12/27/19. -Diagnoses of Schizoaffective Planonary Disease and Tobacco Use Disorder. -Discharge date of 8/16/22. Review on 8/22/22 of Ct #5's record revealed: -Admission date of 12/27 to fic 5's record revealed: -Admission date of 16/16/2. Review on 8/23/22 of the facility's personnel records revealed the following: Staff #1: -No date of hire. -Hired as a Habilitation Technician. -CPR training was completed on 2/2/21 online. -No docomentation of training to meet the mental heath	Division	of Health Service Re	aulation			FORM	APPROVED
MHL032498 B. WING O8/24/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE STREET ADDRESS, CITY, STATE, ZIP CODE URHAM, NC 27707 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST ER FACEORD BY FULL TAG D PREFIX PROVIDER'S FLAN OF CORRECTIVE ACTION SHOLD BE (EACH DEFICIENCY MUST ER FACEORD BY FULL TAG 0 PREFIX (EACH DEFICIENCY MUST ER FACEORD BY FULL TAG 0 PREFIX (EACH DEFICIENCY MUST ER FACEORD BY FULL TAG 0 PREFIX (EACH DEFICIENCY MUST ER FACEORD BY FULL TAG 0	STATEMEN	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA				
MELODY HOUSE#1, LC DITREAM, NC 27707 CMUDE SUMMARY STATEMENT OF DEFICIENCES ULRHAM, NC 27707 PREFIX TAG SUMMARY STATEMENT OF DEFICIENCES REQUATORY OR LSC DENTIFYING INFORMATION) D PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOLD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETE DATE V 108 Continued From page 2 V 108 V 108 Image: Control of C			MHL032-498	98 B. WING			
MELODY HOUSER1, LLC DURHAM, NC 27707 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REQUILATORY OR LSC IDENTIFYING INFORMATION) PD PREFIX TAG PROVIDER'S PLAN OF CORRECTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REQUILATORY OR LSC IDENTIFYING INFORMATION) PD PREFIX TAG PROVIDER'S PLAN OF CORRECTION SHOULD BE (EACH DEFICIENCY) OWNED TAG V 108 Continued From page 2 V 108 V 108 EACH DEFICIENCY) OWNED TAG DEFICIENCY) V 108 c. Review on 8/22/22 of client #3's record revealed: -Admission date of 7/29/19. -Diagnoses of Schizophrenia, Hypertension, Hyperlipidemia, Morbid Obesity, Vitamin D Deficiency and Normocytic Anemia. I. Review on 8/22/22 of client #4's record revealed: -Admission date of 12/27/19. -Diagnoses of Schizoaffective Disorder-Bipolar type, Hypertension, Coronary Artery Disease, Type II Diabetes, Nornheumatic Aortic Valve Insufficiency and History of Ascending Aortic Aneurysm. I. Review on 8/22/22 of FC #5's record revealed: -Admission date of 41/6/14. -Diagnoses of Schizophrenia-Paranoid Type, Osteopenia, Chronic Obstructive Pulmonary Disease and Tobacco Use Disorder. -Discharge date of 8/16/22. Review on 8/23/22 of the facility's personnel records revealed the following: Staff #1: -No date of hire. -Hired as a Habilitation Technician. -OPER training was completed on 22/21 online. -No documentation of training to meet the mental health and developmental disability needs of the clients as specified in the treatment/habilitation	NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
DURHAM, NC 21/07 PRETX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDE BY FULL REGULTORY OR LSC IDENTIFYING INFORMATION) D PRETX TAG PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLETE DATE V 108 Continued From page 2 V 108 V 108 D CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) D DATE V 108 Continued From page 2 V 108 V 108 D CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) D D DEFICIENCY V 108 Continued From page 2 V 108 V 108 D CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) V 108 Continued From page 2 V 108 V 108 D CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) D DEFICIENCY V 108 Continued From page 2 V 108 V 108 D CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY V 109 Collagnoses of Schizoaffenenia, Morbid Obesity, Vitamin D Deficiency and History of Ascending Aortic Aneurysm. A Review on 8/22/22 of FC #5's record revealed: -Admission date of 4/16/14. -Diagnoses of Schizoafter Junonary Disease and Tobacco Use Disorder. D Discase and Tobacco Use Disorder. D Discharge date of 8/16/22. E Review on 8/23/22 of the facility's personnel records revealed the following: Staff #1: -No dace of hire. -Hired as a Habilitation T			3116 CED		RIVE		
PRÉFIX TAG IEACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PRÉFIX TAG CEACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLETE DATE V 108 Continued From page 2 V 108 V 108 Image: Cross-Reference Correction Correction Should be cross-Reference Correction Correction Should be cross-Reference Correction Cor	MELODI	10002#1, 220	DURHAM	, NC 27707			
 c. Review on 8/22/22 of client #3's record revealed: -Admission date of 7/29/19. -Diagnoces of Schizophrenia, Hypertension, Hyperlipidemia, Morbid Obesity, Vitamin D Deficiency and Normocytic Anemia. d. Review on 8/22/22 of client #4's record revealed: -Admission date of 12/27/19. -Diagnoses of Schizoaffective Disorder-Bipolar type, Hypertension, Coronary Artery Disease, Type II Diabetes, Nonrheumatic Aortic Valve Insufficiency and History of Ascending Aortic Aneurysm. e. Review on 8/22/22 of FC #5's record revealed: -Admission date of 4/16/14. -Diagnoses of Schizophrenia-Paranoid Type, Osteopenia, Chronic Obstructive Pulmonary Disease and Tobacco Use Disorder. -Discharge date of 8/16/22. Review on 8/23/22 of the facility's personnel records revealed the following: Staff #1: -No date of hire. -Hired as a Habilitation Technician. -OPR training was completed on 2/2/21 online. -No documentation of training to meet the mental health and developmental disability needs of the clients as specified in the treatment/habilitation 	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO	LD BE	COMPLETE
revealed: -Admission date of 7/29/19. -Diagnoses of Schizophrenia, Hypertension, Hyperlipidemia, Morbid Obesity, Vitamin D Deficiency and Normocytic Anemia. d. Review on 8/22/22 of client #4's record revealed: -Admission date of 12/27/19. -Diagnoses of Schizoaffective Disorder-Bipolar type, Hypertension, Coronary Artery Disease, Type II Diabetes, Nonrheumatic Aortic Valve Insufficiency and History of Ascending Aortic Aneurysm. e. Review on 8/22/22 of FC #5's record revealed: -Admission date of 4/16/14. -Diagnoses of Schizophrenia-Paranoid Type, Osteopenia, Chronic Obstructive Pulmonary Disease and Tobacco Use Disorder. -Discharge date of 8/16/22. Review on 8/23/22 of the facility's personnel records revealed the following: Staff #1: -No date of hire. -Hired as a Habilitation Technician. -CPR training was completed on 2/2/21 online. -No documentation of training to meet the mental health and developmental disability needs of the clients as specified in the treatment/habilitation	V 108	Continued From pa	ge 2	V 108			
Staff #2: -No date of hire. -Hired as a Habilitation Technician. -No documentation of CPR and FA training. -No documentation of training to meet the mental	V 108	 c. Review on 8/22/2 revealed: -Admission date of -Diagnoses of Schiz Hyperlipidemia, Mod Deficiency and Norred d. Review on 8/22/2 revealed: -Admission date of -Diagnoses of Schiz type, Hypertension, Type II Diabetes, Ne Insufficiency and Hi Aneurysm. e. Review on 8/22/2 -Admission date of -Diagnoses of Schiz Osteopenia, Chroni Disease and Tobace -Discharge date of a Review on 8/23/22 records revealed th Staff #1: -No date of hire. -Hired as a Habilitation -No documentation health and developed clients as specified plan. Staff #2: -No date of hire. -Hired as a Habilitation 	22 of client #3's record 7/29/19. zophrenia, Hypertension, rbid Obesity, Vitamin D mocytic Anemia. 22 of client #4's record 12/27/19. zoaffective Disorder-Bipolar Coronary Artery Disease, onrheumatic Aortic Valve story of Ascending Aortic 22 of FC #5's record revealed: 4/16/14. zophrenia-Paranoid Type, c Obstructive Pulmonary co Use Disorder. 8/16/22. of the facility's personnel e following: tion Technician. completed on 2/2/21 online. of training to meet the mental mental disability needs of the in the treatment/habilitation				

Division of Health Service Regulation STATE FORM

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	CONSTRUCTION		E SURVEY PLETED
			A. BUILDING.		R	
		MHL032-498	B. WING			R 24/2022
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
IELODY	HOUSE#1, LLC		DARWOOD DF M, NC 27707	RIVE		
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PRÉFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLE DATE
V 108	Continued From pa	ige 3	V 108			
		mental disability needs of the in the treatment/habilitation				
	health and develop					
	revealed: -She was employed 2 years. -She worked alone shift. -She had no recent -She thought she re she was hired.	22 and 8/24/22 with staff #1 d with the facility for a little ove with the clients during her training in CPR. eceived the CPR training wher mber if the CPR training was				
	-She left the agenc returned to the facil -She mainly worked worked alone with t -She thought she d towards the end of	d weekends at the facility. She he clients during her shift. id FA and CPR training 2021. mber if the FA and CPR				
	to ensure staff rece -She was responsit FA and CPR trainin	ed: ibility as Program Coordinator ived the required trainings. ole for ensuring staff received				

TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CL IDENTIFICATION NUMBER				(X3) DATE SURVEY COMPLETED	
	BERTH TO ATTOM TO MBER.	A. BUILDING:	A. BUILDING:		
	MHL032-498	B. WING			R 24/2022
ME OF PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
ELODY HOUSE#1, LLC		DARWOOD DR M, NC 27707	RIVE		
X4) ID SUMMARY STA			PROVIDER'S PLAN OF	CORRECTION	(X5)
REFIX (EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	COMPLET DATE
V 108 Continued From pa	age 4	V 108			
those trainers conta -"[The Director/Lice schedule those trai Interview on 8/23/2 revealed: -Staff worked alone shifts at the facility. -She thought the F/ staff was done onlin -The instructor con could be done onlin certified in FA and 0 could not be trained -She didn't realize s training to meet the developmental disa -The Program Cool ensuring staff were CPR trainings. -She confirmed sta training in CPR. -She confirmed sta Coordinator had no meet the mental he disability needs of t treatment/habilitatio	ensee] will not let any one else nings, she does it all herself." 2 with the Director/Licensee e with the clients during their A and CPR trainings for some ne due to Covid. ducting the training said it ne if those staff were previousl CPR. She didn't realize staff d online for CPR. staff were supposed to receive e mental health and ability needs of clients. rdinator was responsible for e scheduled for the FA and ff #1 and staff #2 had no aff #1 and staff #2 had no ff #1, staff #2 and the Program o documentation of training to ealth and developmental the clients as specified in the	y			
NCAC 27G .5601 S	SCOPE (V289) for a Type B nust be corrected within 45				
V 110 27G .0204 Training Paraprofessionals	/Supervision	V 110			

Division of Health Service R TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	CONSTRUCTION		E SURVEY PLETED	
ND FLAN OF CORRECTION	IDENTIFICATION NOMBER.	A. BUILDING:				
	MHL032-498	B. WING			R 08/24/2022	
AME OF PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
IELODY HOUSE#1, LLC			RIVE			
		A, NC 27707			1	
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE	
V 110 Continued From pa	age 5	V 110				
SUPERVISION OF (a) There shall be paraprofessionals. (b) Paraprofession associate profession associate profession subchapter. (c) Paraprofession knowledge, skills a population served. (d) At such time at employment system then qualified profe professionals shall (e) Competence s exhibiting core skil (1) technical know (2) cultural awaren (3) analytical skills (4) decision-makin (5) interpersonal s (6) communication (7) clinical skills. (f) The governing develop and implet for the initiation of plan upon hiring ea	rledge; ness; ;; ng; ;kills;					

	of Health Service Re	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPI F	CONSTRUCTION	(X3) DATE	E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:				PLETED
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		MHL032-498	B. WING		08/24/2022	
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
	(HOUSE#1, LLC	3116 CEI		RIVE		
	110032#1, 220	DURHAN	I, NC 27707			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
V 110	Continued From pa	ige 6	V 110			
	population served.	The findings are:				
	Review on 8/23/22 and 8/24/22 of the facility's personnel records revealed the following:					
	Program Coordinat -Date of hire was 9					
	Director/Licensee: -Date of hire was 8/2005.					
	good decision maki unsupervised in the Coordinator failed t	ensee failed to demonstrate ing by allowing client #2 to be community. Program o ensure safety of client #2 by police department after that sing for two days.				
	-Admission date of -Diagnoses of Schi Type, Obesity, Coc Use Disorder and T	of client #2's record revealed: 8/11/22. zoaffective Disorder-Bipolar aine Use Disorder, Cannabis Type II Diabetes, History of nd Vitamin D Deficiency.				
	revealed: -"On last Friday, Au home reporting that done. Staff alerted Saturday morning t [Program Coordina called hospitals and [client #2]. Her mot frequented an area Coordinator] went t looking for her and missing person rep	of an incident report 8/22/22 igust 19 [Client #2] left the t she was going to get her hair [Program Coordinator] on hat she did not return. tor] contacted her mother, d the jail in hopes of contacting her reported that she of [local city] and [Program here checking on her. After allowing 24 hours to pass a ort was filed. [Client #2] he on this morning, August 22,				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	. ,	CONSTRUCTION		E SURVEY PLETED	
ND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COM	PLETED	
		MHL032-498	B. WING			R 24/2022	
	PROVIDER OR SUPPLIER					0/24/2022	
AME OF F	ROVIDER OR SUPPLIER		DDRESS, CITY, S ⁻ DARWOOD DF				
IELODY	' HOUSE#1, LLC		ANC 27707				
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)	
PRÉFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLE DATE	
V 110	Continued From pa	ge 7	V 110				
- 	Interview on 8/22/22 with client #2 revealed: -She walked away from the facility last Friday						
	morning August 22	he returned to the facility this , 2022. and caught the bus to her					
	Aunt's house.	unt's house to get her hair					
	done. -The Director/Licen get her hair done.	see gave her permission to					
	-She went to visit h accident with her A	er Aunt. She got into a car unt while she was on her visit.					
	accident occurred,	cify where they were when the they were in the local area. any other details about the					
	accident. -She hurt her knee	in the car accident. Her body					
	was a little sore and -She was in the hos 2022 until Monday	spital from Friday August 19,					
	-Her Uncle dropped Monday morning af	I her off at the bus station ter being discharged from the					
	around 7:45 am. It	o the facility Monday morning took her about 30 minutes to					
	walk to the facility. -She left the discha hospital at her Aunt	rge paperwork from the 's house.					
	-She didn't know he could not remember	er Aunt's number and she r the name of the hospital.					
	She knew the hosp	ital was in the local area.					
	-She called the Dire	2 with staff #2 revealed: ector/Licensee on Friday					
		nen client #2 decided she was home. Client #2 said she air done.					
		see gave client #2 permission					

STATE FORM

UXL211

If continuation sheet 8 of 47

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
	or connection	IDENTIFICATION NOMBER.	A. BUILDING:			
		MHL032-498	B. WING		R 08/24/2022	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
MELODY	' HOUSE#1, LLC			live		
			I, NC 27707			()(5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 110	Continued From pa	ige 8	V 110			
	-She thought client pm. -She tried calling cl pm when client #2 -Client #2's mother was not able to loca -Client #2's mother and her mother new -She worked the er not return Saturday -She stayed in cons Coordinator about f -The Program Coord August 21, 2022. T report to the police missing. -Client #2 came ba August 22, 2022 ar Interviews on 8/22/ Program Coordinat -When she came ir around 3:00 pm, st had just walked off -Client #2 told staff hair done. -She drove to place thought client #2. -She thought client she went. -Client #2 knew the the local city. -They called hospit showing up and she	 #2 left the facility around 3:00 ient #2's mother around 9:00 failed to return. tried to contact the Aunt and ate her or client #2. said she would call back later ver called back after that. ntire weekend and client #2 did or Sunday. stant contact with the Program the incident with client #2. rdinator came over on Sunday he Program Coordinator did a department that client #2 was ck on her own the morning of ound 7:30 am. 22 and 8/23/22 with the or revealed: n on Friday August 19, 2022 aff #2 informed her client #2 #2 she was going to get her es throughout the weekend she build possibly be. She could not a strong and jails prior to client #2 e could not be located. 				
	weekend. Client #2 abuse and a crimin -She contacted the	e where client #2 was over the had a history of substance al record. Director/Licensee about client the facility on Saturday				

STATE FORM

STATEMEN	of Health Service Re T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SU COMPLET	
			A. BUILDING:			20
		MHL032-498	B. WING		R 08/24/2022	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE		
MELODY	HOUSE#1, LLC		ARWOOD DR , NC 27707	IVE		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF		(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE C	DATE
V 110	Continued From pa	ge 9	V 110			
	client #2 missing ur #2 left on Friday. "If #2] could not be rep later." -The police officers #2 in the communit -Staff #2 called her 2022 and said clien am.	e police department to report ntil Sunday even though client was my understanding [client borted missing until 48 hours were not able to locate client y. the morning of August 22, t #2 showed up around 7:25 a she was in the hospital over				
	Director/Licensee r -Client #2 resided a weeks. -Client #2 had unsu- however she told he was in the facility for -She knew client #2 2022 and returned -Prior to the incider not sign herself out Client #2 wanted to community and get -When she was on told her she could r hair done without st -She thought the ist speaking with client facility unsupervise -She didn't give client Aunt's house to get -According to staff a without permission. -The Program Coord	at the facility for about 2 pervised time approved, er it was not to start until she or 30 days. 2 left the facility on August 19, on August 22, 2022. at she told client #2 she could in order to get her hair done. go to visit her Aunt in the her hair done. the phone with client #2 she not leave the facility to get her taff being with her. sue was "squashed" after t #2 about not leaving the d. ant #2 permission to go to her her hair done. #2, client #2 left the facility				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED
		MHL032-498	B. WING			R 24/2022
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
		3116 CE	DARWOOD DR	RIVE		
IELOD I	'HOUSE#1, LLC	DURHAI	M, NC 27707			
(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 AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
V 110	Continued From pa	ge 10	V 110			
	Program Coordinat client #2 leaving the -When client #2 ret said she got into a while they were out -Client #2 said she weekend. -Client #2 was from like she knew the a -She didn't think cliv really wasn't sure w weekend.	was in the hospital over the the local area and she felt rea. ent #2 was in the hospital. She where client #2 was over the				
	2. The Program Co Director/Licensee fa trainings as require	ailed to ensure staff had				
	to staff trainings: -Staff #1's Cardioput training was completed -Staff #2 had no do or CPR training. -Staff #1, staff #2, C Program Coordinate current training in N (NCI+).	cumentation of First Aid (FA) Qualified Professional and or had no documentation of lational Crisis Intervention +				
	had no training to n	nd the Program Coordinator neet the mental health and bility needs of clients.				
		ordinator and the ailed to ensure staff had the ation in their personnel record				
		V133 for more details related cumentation for personnel				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SUR COMPLETE		
				A. BUILDING:		D	
		MHL032-498	B. WING			R 08/24/2022	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE			
MELOD	(HOUSE#1, LLC		ARWOOD DR , NC 27707	RIVE			
(X4) ID PREFIX	_	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL		PROVIDER'S PLAN OF C		(X5) COMPLET	
TAG		SC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO TH DEFICIENCY	HE APPROPRIATE	DATE	
V 110	Continued From pa	ge 11	V 110				
		are Personnel Registry cessed prior to hire.					
	-Staff #2's HCPR w	as not accessed when she					
	was rehired in April -Staff #1's criminal	2022. history record check had no					
	date.	-					
		history record check was not e was rehired in April 2022.					
		ross referenced into 10A					
		SCOPE (V289) for a Type B Just be corrected within 45					
	days.						
V 114	27G .0207 Emerge	ncy Plans and Supplies	V 114				
	10A NCAC 27G .02 AND SUPPLIES	207 EMERGENCY PLANS					
		n for each facility and plan shall be developed and					
	shall be approved b	by the appropriate local					
	authority. (b) The plan shall b	e made available to all staff					
	and evacuation pro posted in the facility	cedures and routes shall be					
	(c) Fire and disaste	r drills in a 24-hour facility					
		st quarterly and shall be shift. Drills shall be conducted					
	under conditions th	at simulate fire emergencies.					
	accessible for use.	all have basic first aid supplies					
	This Rule is not me						
		views and interviews the ure fire and disaster drills were					
	5	ach shift. The findings are:					

STATEMENT OF DEFICIENCIES (AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
			A. BUILDING:			R
		MHL032-498	B. WING			r. 24/2022
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
MELODY	(HOUSE#1, LLC		DARWOOD DR /I, NC 27707	IVE		
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLET DATE
V 114	Continued From pa	ge 12	V 114			
	revealed: -8/15/22-1st shift -7/14/22-2nd shift -6/1/22-1st shift -5/18/22-1st shift -4/13/22-1st shift -3/29/22-2nd shift -There was no docu a fire drill on 2nd an quarter. Review on 8/22/22 revealed: -7/29/22-1st shift -7/15/22-1st shift -6/4/22-2nd shift -5/28/22-2nd shift -3/22/22-1st shift -3/22/22-1st shift -There was no docu a disaster drill on 3n	of the facility's fire drill log umentation of staff conducting nd 3rd shifts during the 2nd of the facility's disaster drill log umentation of staff conducting rd shift during the 2nd quarter. 2 with client #1 revealed:	3			
	-She thought they d months ago.	this morning with staff. lid a disaster drill about 2-3 lid fire and disaster drills abou <i>r</i> ith them.	t			
	revealed: -The facility had thr -She didn't know sta fire and disaster dri -She confirmed stat	2 with the Director/Licensee ee separate staff shifts. aff were not conducting the lls consistently. ff failed to ensure fire and done quarterly on each shift.				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA NND PLAN OF CORRECTION IDENTIFICATION NUMBER:		Equiation (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
					R	
		MHL032-498	B. WING		08/	24/2022
AME OF I	PROVIDER OR SUPPLIER					
IELODY	HOUSE#1, LLC		DARWOOD DR 1, NC 27707			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLET DATE
V 114	Continued From pa	ge 13	V 114			
	and must be correc	eted within 30 days.				
V 118	27G .0209 (C) Med	lication Requirements	V 118			
	 only be administered order of a person a drugs. (2) Medications shat clients only when a client's physician. (3) Medications, include the administered only builtiensed persons pharmacist or other privileged to prepare (4) A Medication Act all drugs administered on all drugs administered immediate MAR is to include the (A) client's name; (B) name, strength, (C) instructions for (D) date and time the (E) name or initials drug. (5) Client requests checks shall be recorded approximation of the context of t	inistration: non-prescription drugs shall ed to a client on the written uthorized by law to prescribe all be self-administered by uthorized in writing by the cluding injections, shall be by licensed persons, or by a trained by a registered nurse, r legally qualified person and re and administer medications. Iministration Record (MAR) of red to each client must be kept s administered shall be ely after administration. The				

Division	of Health Service Re	egulation			T ONM	APPROVE
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED
		MHL032-498	B. WING		R 08/24/2022	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
MELODY	(HOUSE#1, LLC		ARWOOD DF , NC 27707	RIVE		
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLETE DATE
V 118	Continued From pa	ge 14	V 118			
	interviews, the facil current affecting on clients (#1) and one The findings are: a. Review on 8/22/2 revealed: -Admission date of -Diagnoses of Schi Hypersalivation, Ta Diabetes Insipidus, Vitamin D deficience Pedis.	on, record reviews and ity failed to keep the MARs e of two current audited e of one former client (FC #5). 22 of client #1's record 2/14/19. zoaffective Disorder, chycardia, Nephrogenic Osteopenia, Overweight, sy, Hyperlipidemia and Tinea				
	#1 revealed: -Order dated 2/16/2 (mg) (Sleep Disord about 30 minutes b Nasal Spray 21 mic	of physician's orders for client 22 for Melatonin 3 milligrams ers), one or two tablets nightly efore bedtime and Ipratropium crograms (mcg) (Drooling), nder tongue three times daily				
	am of the medication	tropium Nasal Spray were				
	client #1 revealed:	of the July 2022 MAR for bove were not listed.				
ivision of H	-Admission date of -Diagnoses of Schi	22 of FC #5's record revealed: 4/16/14. zophrenia-Paranoid Type, ic Obstructive Pulmonary				

Division of Health Service Regulation STATE FORM

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			A. BUILDING:	······			
		MHL032-498	B. WING			R 08/24/2022	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE			
MELODY	' HOUSE#1, LLC		DARWOOD DR /I, NC 27707	RIVE			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)	
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	THE APPROPRIATE	COMPLET DATE	
V 118	Continued From pa	ge 15	V 118				
	Disease and Tobac -Discharge date of						
	Review on 8/22/22 of physician's orders revealed: -Order dated 5/23/22 for Clonazepam 0.5 mg (Panic Disorder and Anxiety), one tablet at bedtime and Haloperidol 5 mg (Psychotic Disorders), one tablet at bedtime. -Order dated 2/10/22 for Benztropine Mesylate 1 mg (Parkinson's Disease or Involuntary Movements), one tablet at bedtime.		:				
	client #2 revealed: -Staff failed to put t the MAR for the foll	nazepam 0.5 mg, Haloperidol					
	-Client #1 was adm night as prescribed -Client #1 didn't tak -Staff were docume in July 2022.	2 with staff #2 revealed: inistered the Melatonin every during her shift. e the spray for drooling. enting the Melatonin was given hy the MAR was no longer in					
	Program Coordinat -Clients got their m -There was a secor Melatonin and Iprat client #1 in July 202 -She would normall the MAR book and record books. -She thought she w	edications as prescribed. nd sheet that had the ropium Nasal Spray listed for					

STATE FORM

Division of H	lealth Service Re	gulation			FURI	APPROVED
STATEMENT OF	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY PLETED
			A. BUILDING			
		MHL032-498	B. WING		R 08/24/2022	
NAME OF PROV	VIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE	_	
	OUSE#1, LLC			ORIVE		
	,, 220	DURHAN	I, NC 27707	1		1
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
V 118 Co	ontinued From pa	ge 16	V 118			
-SI tha Sp -SI M/ ad -"T -SI en: -SI cui Int rev -SI clie -SI clie -SI clie -SI cui Un trev -SI clie -SI cui Th Se -SI SE -SI Cui SE -SI -SI -SI -SI -SI -SI -SI -SI -SI -SI	he wasn't sure what listed the Melat oray wasn't in her he thought staff f AR to indicate the ministered for FC That was my fault he was responsit sure there are no he confirmed stat rrent for client #1 erview on 8/23/22 vealed: taff administered ent #1 and FC #5 he spoke with the cond page of the he Program Coor nat happened to t ly MAR. he Program Coor ecking MARs for he confirmed stat rrent for client #1 ue to the failure to edication adminis termined if clients ordered by the p his deficiency is choose CAC 27G .5601 S	hy the July MAR for client #1 conin and Ipratropium Nasal record book. orgot to sign the June 2022 medications were #5. I should have caught that." of for checking the MARs to issues. If failed to keep the MARs and FC #5. 2 with the Director/Licensee the prescribed medications to idaily. Program Coordinator about July 2022 MAR for client #2. dinator said she wasn't sure he second page of client #2's rdinator was responsible for medication errors. If failed to keep the MARs and FC #5.				
V 121 27		ication Requirements	V 121			
		09 MEDICATION				
ivision of Health	Service Regulation		6899	UXL211	If continuati	on sheet 17 of

TATEMEN	of Health Service Re IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED
		MHL032-498	B. WING			R 24/2022
IAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
IELODY	' HOUSE#1, LLC		DARWOOD DF M, NC 27707	RIVE		
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
V 121	Continued From pa	ige 17	V 121			
	governing body or of for obtaining a revie regimen at least ev shall be to be perfor physician. The on-se the client's physicia the review when mo- (2) The findings of	eives psychotropic drugs, the operator shall be responsible ew of each client's drug ery six months. The review rmed by a pharmacist or site manager shall assure that in is informed of the results of edical intervention is indicated the drug regimen review shall client record along with				
	facility failed to obta six months for one	et as evidenced by: view and interviews, the ain drug regimen reviews ever of one former client (Former sived psychotropic drugs. The				
	-Admission date of -Diagnoses of Schi Osteopenia, Chron Disease and Tobac -Discharge date of -Drug regimen revi 11/12/21. -Medication Form of	zophrenia-Paranoid Type, ic Obstructive Pulmonary cco Use Disorder. 8/16/22. ew was completed on dated 5/17/22-Pharmacist cation Regimen Review)-note				
	-Order dated 5/23/2	of physician's orders revealed 22 for Clonazepam 0.5 anic Disorder and Anxiety), one				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED	
		MHL032-498	B. WING		R 08/24/2022		
					08/	08/24/2022	
IAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, S ⁻				
IELODY	'HOUSE#1, LLC		M, NC 27707				
(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 (EACH CORRECTIVE AC CROSS-REFERENCED TO	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE	
				DEFICIENC	CY)		
V 121	Continued From pa	ige 18	V 121				
	tablet at bedtime and Haloperidol 5 mg (Psychotic Disorders), one tablet at bedtime.		c				
	Review on 8/22/22	of the Medication					
		ord (MAR) revealed:					
		cumented FC #5 was pove medications for the entire	ę				
	month.						
		ocumented FC #5 was pove medications for the entire					
	month.	sove medications for the entire	÷				
	Review on 8/22/22	of facility records revealed:					
	-There was no evid	ence of a current drug					
	regimen review cor months for FC #5.	npleted within the last six					
	Interview on 8/22/2 Coordinator reveale						
		nailed the psychotropic drug he Director/Licensee for FC					
		e Director/Licensee opened					
		pharmacist sent that					
	document to her. -Initially, she didn't	know the document was					
	emailed until she ju	ist looked at the document in					
	FC #5's client recor	^r d. re was no documentation of a					
		w completed for FC #5 within					
	the last six months.						
		2 with the Director/Licensee					
	revealed:	he Pharmacist emailed FC					
		rug regimen review to her in					
	May 2022.						
		rdinator was responsible for drug regimen reviews. That					
		regimen review for FC #5					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		E SURVEY PLETED	
	OF CONNECTION	IDENTIFICATION NOWBER.	A. BUILDING:				
		MHL032-498	B. WING			R 08/24/2022	
AME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
	HOUSE#1, LLC	3116 CE	DARWOOD DF	RIVE			
	100002#1, 220	DURHAN	I, NC 27707			1	
(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 AC' CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE	
V 121	Continued From pa	ge 19	V 121				
	Coordinator. -She confirmed the	emailed to the Program re was no documentation of a w completed for FC #5 within					
V 131	G.S. 131E-256 (D2 Verification) HCPR - Prior Employment	V 131				
	REGISTRY (d2) Before hiring h health care facility of health care facility of Personnel Registry	EALTH CARE PERSONNEL ealth care personnel into a or service, every employer at a shall access the Health Care and shall note each incident propriate business files.	1				
	facility failed to ens Registry (HCPR) w employment affecti and #2). The findir	views and interviews, the ure the Health Care Personne as accessed prior to ng two of four audited staff (#1					
	records revealed th Staff #1: -No date of hire. -Hired as a Habilita	tion Technician. the HCPR was accessed					

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY PLETED	
			A. BUILDING.	· · · · · · · · · · · · · · · · · · ·			
		MHL032-498	B. WING			R 08/24/2022	
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE			
MELOD	Y HOUSE#1, LLC		DARWOOD DR	RIVE			
	-		I, NC 27707				
(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 THE APPROPRIATE	(X5) COMPLET DATE	
V 131	Continued From pa	ige 20	V 131				
	when she was rehin Interview on 8/22/2 -She was employed 2 years. Interview on 8/23/2 -She left the agency returned to the facil Interview on 8/23/2 Coordinator reveale -It was her respons Coordinator to ensu documentation in th -She was responsit was accessed for a responsibility, the D	eed on 9/30/20. the HCPR was accessed red in April 2022. 2 with staff #1 revealed: d with the facility for a little over 2 with staff #2 revealed: y in December 2021 and lity in April 2022. 2 with the Program ed: ibility as the Program ure staff had the required heir personnel folders. ole for making sure the HCPR ill staff. Although it was her Director/Licensee would access					
	Director/Licensee r -She thought the H #1. -Staff #2 just return She didn't realize s the HCPR for staff -The Program Cool ensuring the HCPR staff. -She did the HCPR because the Progra available. -She confirmed the	22 and 8/24/22 with the					

Division of Health Service F STATE FORM

Division	of Health Service Re	aulation			FORM	APPROVED
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		MHL032-498	B. WING		R 08/24/2022	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
MELODY	HOUSE#1, LLC		ARWOOD DF , NC 27707	RIVE		
				PROVIDER'S PLAN OF CORRECTION		(ME)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION ADDITION (EACH CORRECTIVE ACTION ADDITION ADDITIONA ADDITION ADDITIONA ADDITICA ADDITIONA ADDITICA AD	D BE	(X5) COMPLETE DATE
V 131	Continued From pa	ge 21	V 131			
	prior to employmen	t.				
	NCAC 27G .5601 S	ross referenced into 10A COPE (V289) for a Type B ust be corrected within 45				
V 133	G.S. 122C-80 Crim	inal History Record Check	V 133			
	CHECK REQUIRED APPLICANTS FOR (a) Definition As u "provider" applies to program and any pr developmental disa services that is licer Chapter. (b) Requirement A provider licensed un applicant to fill a po applicant to have an conditioned on cons criminal history reco the applicant has be less than five years is conditioned on cons criminal history reco national criminal his include a check of to the applicant has be five years or more, on consent to a Sta check of the applican criminal history reco section. Except as o subsection, within fi					

Division	of Health Service Re	egulation	-			
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			e survey IPleted
		MHL032-498	B. WING		R 08/24/2022	
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
		3116 CEI		RIVE		
MELODY	'HOUSE#1, LLC	DURHAN	I, NC 27707			
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG	,	/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLETE DATE
V 133	Continued From pa	ge 22	V 133			
	shall submit a requ	est to the Department of				
		114-19.10 to conduct a				
	criminal history reco	ord check required by this				
	section or shall sub	mit a request to a private				
		State criminal history record				
	check required by this section. Notwithstanding					
	G.S. 114-19.10, the Department of Justice shall return the results of national criminal history					
		mployment positions not				
	covered by Public L					
		Ith and Human Services,				
	Criminal Records Check Unit. Within five					
	business days of receipt of the national criminal					
	history of the person, the Department of Health					
		es, Criminal Records Check				
		provider as to whether the				
		d may affect the employability				
		no case shall the results of the)			
		story record check be shared roviders shall make available				
		cation that a criminal history				
		mpleted on any staff covered				
		ounty that has adopted an				
	appropriate local or	dinance and has access to				
	the Division of Crim	inal Information data bank				
		half of a provider a State				
		ord check required by this				
		provider having to submit a				
		artment of Justice. In such a all commence with the State				
		ord check required by this				
	section within five b					
		employment by the provider.				
		nformation received by the				
		itial and may not be disclosed,				
	except to the applic	ant as provided in subsection				
	(c) of this section. F	or purposes of this				
		n "private entity" means a engaged in conducting				

Division of Health Service Reg STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	ECONSTRUCTION		SURVEY
	MHI 032-498			(X3) DATE SURVEY COMPLETED	
	MHL032-498			R 08/24/2022	
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
	3116 CED	ARWOOD DI	RIVE		
MELODY HOUSE#1, LLC	DURHAM	, NC 27707			
PREFIX (EACH DEFICIENCY N	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL CIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
V 133 Continued From page	e 23	V 133			
records obtained from (c) Action If an app record check reveals a relevant offense, the of the following factor hire the applicant: (1) The level and ser (2) The date of the cr (3) The age of the per conviction. (4) The circumstance commission of the cr (5) The nexus betweet the person and the jo filled. (6) The prison, jail, per rehabilitation, and em person since the date (7) The subsequent of a relevant offense. The fact of conviction shall not be a bar to a listed factors shall be of the provider disquar consideration of the r provider may disclose the criminal history re to the disqualification of the criminal history re	blicant's criminal history one or more convictions of the provider shall consider all rs in determining whether to iousness of the crime. rime. erson at the time of the es surrounding the time, if known. en the criminal conduct of ob duties of the position to be robation, parole, hployment records of the e the crime was committed. commission by the person of n of a relevant offense alone employment; however, the e considered by the provider. difies an applicant after relevant factors, then the e information contained in ecord check that is relevant a, but may not provide a copy				

Division	of Health Service Re	egulation				APPROVED
	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:			E SURVEY IPLETED
		MHL032-498	B. WING			R / 24/2022
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
		3116 CEE	DARWOOD DF	RIVE		
WELOD	Y HOUSE#1, LLC	DURHAM	I, NC 27707			
(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 DEFICIENCY)	I SHOULD BE	(X5) COMPLETE DATE
V 133	Continued From pa	ge 24	V 133			
	criminal offenses if history record check compliance with this (e) Relevant Offense" in federal criminal hist indictment of a crim felony, that bears up have responsibility persons needing m disabilities, or subst crimes include the of any of the following General Statutes: A Issuing Monetary S Endangering Execu Article 6, Homicide; Sex Offenses; Artic Kidnapping and Abo Injury or Damage b Incendiary Device of and Other Housebr Other Burnings; Art Robbery; Article 18 False Pretenses an Obtaining Property Fraudulent Use of O Article 19B, Financi Act; Article 20, Frau 26, Offenses Agains Decency; Article 35, O Peace; Article 35, O Peace; Article 36A, Article 39, Protectio Protection of the Fa- Intoxication; and Ar	the employee's criminal k is requested and received in				

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY PLETED	
			A. BUILDING.			R	
		MHL032-498	B. WING			08/24/2022	
NAME OF	PROVIDER OR SUPPLIER		DDRESS, CITY, ST				
MELOD	Y HOUSE#1, LLC		DARWOOD DR 1, NC 27707	RIVE			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE	
V 133	Continued From pa	age 25	V 133				
	Controlled Substan 90 of the General S offenses such as s violation of G.S. 18 impaired in violation G.S. 20-138.5. (f) Penalty for Furn applicant for emplo supplies, or otherw an employment appl criminal history rec shall be guilty of a G (g) Conditional Employ employ an applicar obtaining the result check regarding the following requirement (1) The provider sh prior to obtaining the criminal history rec subsection (b) of the fingerprint cards as (2) The provider sh criminal history rec business days after conditional employ 2001-155, s. 1; 200 2005-4, ss. 1, 2, 3, This Rule is not me Based on record ref facility failed to ensigned check was request	lation of the North Carolina ices Act, Article 5 of Chapter Statutes, and alcohol-related ale to underage persons in B-302 or driving while in of G.S. 20-138.1 through ishing False Information Any oyment who willfully furnishes, ise gives false information on plication that is the basis for a ord check under this section Class A1 misdemeanor. ployment A provider may at conditionally prior to is of a criminal history record e applicant if both of the ents are met: all not employ an applicant he applicant's consent for ord check as required in his section or the completed a required in G.S. 114-19.10. hall submit the request for a ord check not later than five r the individual begins ment. (2000-154, s. 4; 04-124, ss. 10.19D(c), (h); 4, 5(a); 2007-444, s. 3.)					

Division	of Health Service Re	equiation			FORM	APPROVED
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		MHL032-498	B. WING	B. WING		R 24/2022
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
MELODY	HOUSE#1, LLC		DARWOOD DF II, NC 27707	RIVE		
(X4) ID						
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
V 133	Continued From pa	ge 26	V 133			
	affecting two of four The findings are:	r audited staff (#1 and #2).				
	Review on 8/23/22 records revealed th	of the facility's personnel e following:				
	Staff #1: -No date of hire. -Hired as a Habilitation Technician. -Criminal history record check had no date indicated.					
	9/30/20. -No documentation	tion Technician. cord check was requested on a criminal history record ed when she was rehired in				
		2 with staff #1 revealed: I with the facility for a little over	r			
		2 with staff #2 revealed: y in December 2021 and ity in April 2022.				
	to ensure staff had their personnel fold -She was responsib criminal history reco staff. Although it wa	ed: ibility as Program Coordinator the required documentation in ers. ole for making sure the ord check was requested for is her responsibility the yould request the criminal				

Division	of Health Service Re	egulation			
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		MHL032-498	B. WING		R 08/24/2022
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	ATE, ZIP CODE	
MELODY	HOUSE#1, LLC		DARWOOD DR	IVE	
	-		I, NC 27707		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE COMPLETE THE APPROPRIATE DATE
V 133	Continued From pa	ge 27	V 133		
	Director/Licensee m -She wasn't sure wi check was not date -Staff #2 just return She didn't realize si the criminal history she rehired her. -She thought the Q Program Coordinat the criminal history -She did the criminal because it was not Professional or Pro -She confirmed the criminal history reco within five business conditional offer of staff #2.	hy staff #1's criminal history d. ed to the agency in April 2022. he was supposed to request record check for staff #2 when ualified Professional and or were both responsible for record checks. al background in the past completed by the Qualified gram Coordinator. facility failed to ensure the ord check was requested days of making the employment for staff #1 and			
	NCAC 27G .5601 S	ross referenced into 10A SCOPE (V289) for a Type B sust be corrected within 45			
V 289	27G .5601 Supervis	sed Living - Scope	V 289		
	provides residential home environment these services is th rehabilitation of indi illness, a developm or a substance abu supervision when ir (b) A supervised liv the facility serves e	ng is a 24-hour facility which services to individuals in a where the primary purpose of e care, habilitation or viduals who have a mental ental disability or disabilities, se disorder, and who require in the residence. ving facility shall be licensed if			

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Division	of Health Service Re	egulation				APPROVED
STATEME	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		MHL032-498	B. WING		R 08/24/2	
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DRESS, CITY, S	TATE, ZIP CODE		
MELOD	Y HOUSE#1, LLC		DARWOOD DF 1, NC 27707	RIVE		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	DRRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	COMPLETE
V 289	Continued From pa	ge 28	V 289			
	Minor and adult clies same facility. (c) Each supervise licensed to serve a designated below: (1) "A" design serves adults whos illness but may also (2) "B" design serves minors whos developmental disa diagnoses; (3) "C" design serves adults whos developmental disa diagnoses; (4) "D" design serves minors whos substance abuse d other diagnoses; (5) "E" design serves adults whos substance abuse d other diagnoses; or (6) "F" design private residence, w three adult clients w mental illness but n disabilities, or three clients whose prima developmental disa other disabilities wf family provides the exempt from the fo .0201 (a)(1),(2),(3), (A),(B),(E),(F),(G),((18) and (b); 10A N	nation means a facility in a which serves no more than whose primary diagnoses is nay also have other adult clients or three minor				

Division	of Health Service Re	equiation			FORM	APPROVED
STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		MHL032-498	B. WING			R 24/2022
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
MELODY	(HOUSE#1, LLC		DARWOOD DF 1, NC 27707	RIVE		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF (CORRECTION	(X5)
PRÉFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLETE DATE
V 289	Continued From pa	ge 29	V 289			
	27G .0208 (b),(e); non-prescription me (1)(A),(D),(E);(f);(g) (b)(2),(d)(4). This f	27G .0207 (b),(c); 10A NCAC 10A NCAC 27G .0209[(c)(1) - edications only] (d)(2),(4); (e) and 10A NCAC 27G .0304 acility shall also be known as ving or assisted family living				
	interviews, the facil scope of the progra provide services for care and supervision	ion, record reviews and ity failed to operate within the am developed and designed to r habilitation/rehabilitation, on affecting four of four current and #4) and one of one former				
	PERSONNEL REQ Based on record re facility failed to ens (#1 and #2) had tra Resuscitation (CPF (#2) had training in audited staff (#1, #2 had training to mee developmental disa	OA NCAC 27G .0202 UIREMENTS (Tag 108) views and interviews, the ure two of four audited staff ining in Cardiopulmonary R); one of four audited staff First Aid (FA) and three of four 2 and Program Coordinator) to the mental health and ability needs of the clients as atment/habilitation plan.				
Division of H	COMPETENCIES A PARAPROFESSIO Based on record re five staff (the Progr Director/Licensee)	OA NCAC 27G .0204 AND SUPERVISION OF NALS (Tag 110) views and interviews two of am Coordinator and the failed to demonstrate the nd abilities required for the				

AND PLAN OF CORRECTION				(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED R 08/24/2022	
AME OF PRO	VIDER OR SUPPLIER		DDRESS, CITY, ST	ATE, ZIP CODE			
IELODY H	DUSE#1, LLC		DARWOOD DR /I, NC 27707	IVE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	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	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
DO CI M Bâ in cu cli Cl Cl Bâ fa R er ar CI H CI Bâ fa ch m af CI T R Bâ fa (# Pi Bâ fa CI Cl Bâ fa R er ar CI H CI Cl Bâ fa R er ar CI Bâ fa R er ar CI Cl Bâ fa R er ar CI Cl Bâ fa R er ar CI Cl Bâ fa R er ar CI Cl Bâ fa R er ar CI Cl Bâ fa R er ar CI Cl Bâ fa R er ar CI Cl Bâ fa R er ar CI Cl Bâ fa R er ar CI Cl Bâ fa C Cl Bâ fa R er ar CI C Cl Bâ fa CI C Cl Bâ fa CI C C C C C C C C C C C C C C C C C C	EDICATION REQ ased on observati terviews, the facili irrent affecting on ents (#1) and one ross Reference: C ARE PERSONNE ased on record re cility failed to ensu- egistry (HCPR) wan nployment affectin ad #2). ross Reference: C ISTORY RECORI ERTAIN APPLICA ag 133) ased on record re cility failed to ensu- neck was requeste aking the condition fecting two of four ross Reference: 1 RAINING ON ALT ESTRICTIVE INT ased on record re cility failed to ensu- tased on record re cility failed to ensu- ased on record re cility failed to ensu- tased on record re cility failed to ensu- tased on record re cility failed to ensu- 1, #2, Program C rofessional) had tr ternatives to restr	0A NCAC 27G .0209 QUIREMENTS (Tag 118) on, record reviews and ity failed to keep the MAR e of two current audited e of one former client (FC #5). G.S. §131E-256 HEALTH IL REGISTRY (Tag 131) views and interviews, the ure the Health Care Personne as accessed prior to ing two of four audited staff (#1 G.S. §122C-80 CRIMINAL D CHECK REQUIRED FOR NTS FOR EMPLOYMENT views and interviews, the ure the criminal history record ed within five business days of inal offer of employment r audited staff (#1 and #2). 0A NCAC 27E .0107		DEFICIENC			

Division	of Health Service Re	egulation			FORM	APPROVED
STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:			E SURVEY PLETED
		MHL032-498	B. WING			R 24/2022
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	TATE. ZIP CODE		
			DARWOOD DF			
MELODY	Y HOUSE#1, LLC		I, NC 27707			
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLETE DATE
V 289	Continued From pa	ge 31	V 289			
	facility failed to ens (#1, #2, Program C Professional) had the physical restraints at a. Review on 8/22/2 revealed: -Admission date of -Diagnoses of Schit Hypersalivation, Ta Diabetes Insipidus, Vitamin D deficience Pedis. -Client #1 had no d diagnosis of a deve	zoaffective Disorder, chycardia, Nephrogenic Osteopenia, Overweight, cy, Hyperlipidemia and Tinea ocumentation that indicated a elopmental disability.				
	Type, Obesity, Coc Use Disorder and T Seizure Disorder ar -Client #2 had no d	zoaffective Disorder-Bipolar aine Use Disorder, Cannabis Type II Diabetes, History of nd Vitamin D Deficiency. ocumentation that indicated a elopmental disability.				
	revealed: -Admission date of -Diagnoses of Schi Hyperlipidemia, Mo Deficiency and Nor -Client #3 had no d	zophrenia, Hypertension, rbid Obesity, Vitamin D				
ivision of H	revealed: -Admission date of	22 of client #4's record 12/27/19. zoaffective Disorder-Bipolar				

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OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA				
	IDENTIFICATION NUMBER:				E SURVEY PLETED
	MHL032-498	B. WING		R 08/24/2022	
ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE. ZIP CODE		
		ARWOOD DR			
HOUSE#1, LLC		, NC 27707			
		ID			(X5)
		PREFIX TAG			COMPLET DATE
Continued From pa	ge 32	V 289			
 289 Continued From page 32 type, Hypertension, Coronary Artery Disease, Type II Diabetes, Nonrheumatic Aortic Valve Insufficiency and History of Ascending Aortic Aneurysm. Client #4 had no documentation that indicated a diagnosis of a developmental disability. e. Review on 8/22/22 of FC #5's record revealed: -Admission date of 4/16/14. -Diagnoses of Schizophrenia-Paranoid Type, Osteopenia, Chronic Obstructive Pulmonary Disease and Tobacco Use Disorder. -Discharge date of 8/16/22. -FC #5 had no documentation that indicated a diagnosis of a developmental disability. 					
 -FC #5 had no documentation diagnosis of a developmental of linterviews on 8/22/22 and 8/24 Director/Licensee revealed: -She acknowledged none of the documented developmental di -An assessment was done in ter #1, #3, #4 and FC #5 by the particle those clients having a disability diagnosis. -Client #2 was just admitted to weeks ago, she was still trying additional paperwork for her. -She reached out to the Local Entity/Managed Care Organiza after the March 2022 survey. -She was inquiring about a letter clients whose primary diagnosi illness. The person she spoke LME/MCO said there were no available for that service categoditional paper of the service categoditio	evealed: I none of the clients had a opmental disability diagnosis. Is done in the past for clients to by the psychiatrist. eceived any type of paperwork nts having a developmental admitted to the facility about 2 s still trying to get some sk for her. the Local Management re Organization (LME/MCO) 2 survey. about a letter of support for ary diagnosis was mental she spoke with from the re were no letters of support rvice category. facility failed to operate within				
	(EACH DEFICIENCY REGULATORY OR LS Continued From pa ype, Hypertension, ype II Diabetes, Ne neufficiency and Hi aneurysm. Client #4 had no do liagnosis of a deve e. Review on 8/22/2 Admission date of Diagnoses of Schiz Disease and Tobacc Discharge date of a FC #5 had no docu liagnosis of a deve nterviews on 8/22/2 Director/Licensee re She acknowledged locumented develo An assessment wa e1, #3, #4 and FC # The facility never re to reflect those clier lisability diagnosis. Client #2 was just a veeks ago, she was idditional paperwor She reached out to Entity/Managed Cal fter the March 202 She was inquiring a lients whose prima liness. The person ME/MCO said their vailable for that se She confirmed the he scope of the lice	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 32 ype, Hypertension, Coronary Artery Disease, ype II Diabetes, Nonrheumatic Aortic Valve nsufficiency and History of Ascending Aortic vneurysm. Client #4 had no documentation that indicated a liagnosis of a developmental disability. e. Review on 8/22/22 of FC #5's record revealed: Admission date of 4/16/14. Diagnoses of Schizophrenia-Paranoid Type, Osteopenia, Chronic Obstructive Pulmonary Disease and Tobacco Use Disorder. Discharge date of 8/16/22. FC #5 had no documentation that indicated a liagnosis of a developmental disability. hterviews on 8/22/22 and 8/24/22 with the Director/Licensee revealed: She acknowledged none of the clients had a locumented developmental disability diagnosis. An assessment was done in the past for clients 1, #3, #4 and FC #5 by the psychiatrist. The facility never received any type of paperwork to reflect those clients having a developmental lisability diagnosis. Client #2 was just admitted to the facility about 2 weeks ago, she was still trying to get some dditional paperwork for her. She reached out to the Local Management Entity/Managed Care Organization (LME/MCO) ofter the March 2022 survey. She was inquiring about a letter of support for lients whose primary diagnosis was mental lness. The person she spoke with from the .ME/MCO said there were no letters of support vailable for that service category. She confirmed the facility failed to operate within the scope of the licensure. Review on 8/24/22 of a Plan of Protection written	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG Continued From page 32 V 289 ype, Hypertension, Coronary Artery Disease, ype II Diabetes, Nonrheumatic Aortic Valve nsufficiency and History of Ascending Aortic weurysm. V 289 Client #4 had no documentation that indicated a liagnosis of a developmental disability. V e. Review on 8/22/22 of FC #5's record revealed: Admission date of 4/16/14. Diagnoses of Schizophrenia-Paranoid Type, Osteopenia, Chronic Obstructive Pulmonary Disease and Tobacco Use Disorder. Discharge date of 8/16/22. FC #5 had no documentation that indicated a liagnosis of a developmental disability. netrviews on 8/22/22 and 8/24/22 with the Director/Licensee revealed: She acknowledged none of the clients had a locumented developmental disability diagnosis. An assessment was done in the past for clients 11, #3, #4 and FC #5 by the psychiatrist. The facility never received any type of paperwork to reflect those clients having a developmental lisability diagnosis. Client #2 was just admitted to the facility about 2 weeks ago, she was still trying to get some idditional paperwork for her. She reached out to the Local Management intity/Managed Care Organization (LME/MCO) ifter the March 2022 survey. She was inquiring about a letter of support for lients whose primary diagnosis was mental liness. The person she spoke with from the ME/MCO said there were no letters of support ivailable for that service	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION) TAG Continued From page 32 V 289 ype, Hypertension, Coronary Artery Disease, ype II Diabetes, Nonrheumatic Aortic Valve sufficiency and History of Ascending Aortic neurysm. V 289 Client #4 had no documentation that indicated a liagnosis of a developmental disability. Review on 8/22/22 of FC #5's record revealed: Admission date of 4/16/14. Discharge date of 8/16/22. FC #5/s record revealed: Admission date of 4/16/14. Discharge date of 8/16/22. FC #5 had no documentation that indicated a liagnosis of a developmental disability. Discharge date of 8/16/22. FC #5 had no documentation that indicated a liagnosis of a developmental disability. Netreviews on 8/22/22 and 8/24/22 with the Director/Licensee revealed: She acknowledged none of the clients had a locumented developmental disability diagnosis. An assessment was done in the past for clients 1; #3, #4 and #A FC #5 by the psychiatrist. The facility never received any type of paperwork or effect those clients having a developmental lisability diagnosis. Client #2 was just admitted to the facility about 2 weeks ago, she was still trying to get some dditional paperwork for her. She reached out to the Local Management intity/Managed Care Organization (LME/MCO) (fret the March 2022 survey. She was inquiring about a letter of support for ilients whose primary diagnosis was mental l	SUMMARY STATEMENT OF DEFICIENCIES EACH EFFECTENCY MIST RE PRÉCEDED BY FULL REGULATORY OR LSC DENTIFYING INFORMATION) IP PREFIX TAG PREFIX (EACH CORRECTIVE ACTION STOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Sontinued From page 32 ype, Hypertension, Coronary Artery Disease, ype II Diabetes, Nonrheumatic Aortic Valve nsufficiency and History of Ascending Aortic neurysm. V 289 V Client #4 had no documentation that indicated a liagnosis of a developmental disability. V Sector Review on 8/22/22 of FC #5's record revealed: Admission date of 4/16/14. Sector Sector Discharge date of 8/16/22. FC #5's record revealed: Discharge date of 8/16/22. FC #5's necord revealed: Alfamission date of 4/16/14. Discopenia, Chronic Obstructive Pulmonary Disease and Tobacco Use Disorder. Discharge date of 8/16/22. Discharge date of 8/16/22. FC #5 had no documentation that indicated a liagnosis of a developmental disability. nterviews on 8/22/22 and 8/24/22 with the Director/Licensee revealed: She acknowledged none of the clients had a locumented developmental disability diagnosis. An assessment was done in the past for clients that a disability diagnosis. Client #2 was just admitted to the facility about 2 weeks ago, she was still trying to get some dditional paperwork for her. She reached out to the Local Management inity/Managed Care Organization (LME/MCO) fire the March 2022 survey. She was finguring about a letter of support for lients whose primary diagnosis was mental lness. The person she sp

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
						-
		MHL032-498	B. WING		R 08/24/2022	
AME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, ST			
IELODY	HOUSE#1, LLC		DARWOOD DR /I, NC 27707	RIVE		
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PRÉFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLET DATE
V 289	Continued From pa	ge 33	V 289			
	by the Qualified Pro	ofessional and the				
		lated 8/24/22 revealed:				
	"What immediate a	ction will the facility take to				
	ensure the safety o	f the consumers in your care?				
	[The Director/Licen	see] and [the Qualified				
	Professional] will meet with staff immediately to					
	ensure that there is a clear understanding of how					
	to ensure consumers are safe. Staff will receive					
		training in how to deal with Mental Illness and				
		Developmentally disable consumers. This training will be provided by [Qualified Professional] Staff				
	will be provided by [Qualified Professional]. Staff will receive training manage to include the correct					
	way of completing					
		ord). Staff will be scheduled to				
		and CPR (Cardiopulmonary				
		ing. The certificates to confirm				
		oletion of NCI (National Crisis	-			
	•	completed. [The Qualified				
	Professional] will co	omplete criminal history				
	checks and Health	Care Registry on each staff				
		ctor/Licensee] will again				
		Management Entity/Managed				
		to request a letter of support				
		licensure. Consumer who				
		ility will no longer have				
		in the community. Describe				
		sure the above happens.				
		acking system will be				
		sure that certifications do not be implemented to address				
		away and staff will be update				
		diately. Staff meetings will be				
	held more often to					
		erstanding Melody House				
		lures regarding consumers."				
	The facility served	clients whose diagnoses				
	included: Schizoaff	ective Disorder,				
		betes, Nephrogenic Diabetes				
	Insipidus, Coronary					1

Division	of Health Service Re	egulation			FORM	APPROVED
STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		MHL032-498	B. WING			२ 2 4/2022
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
	(HOUSE#1, LLC		ARWOOD DF	RIVE		
MELOD	1100002#1, 220	DURHAM	, NC 27707			
(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 APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
V 289	Continued From pa	ge 34	V 289			
	Nonrheumatic Aorti Ascending Aortic Ar Pulmonary Disease Seizure Disorder, H Cocaine Use Disord Disorder. None of th facility had a diagno Disability. Client #2 permission on Augu August 22, 2022. T Program Coordinate department until Au #2 missing. Facility alone in the facility of training in CPR, I alternatives to restr Restrictive Interven Restraint and Isolat Coordinator and Qu no documentation of Restrictive Interven Restraint and Isolat Director/Licensee of responsible for ensi- current and person required documentation completed. The Me Records for client # current by staff. Stat the July 2022 MAR Melatonin to be adr Ipratropium Nasal S This deficiency con- which is detrimentation welfare of the client corrected within 45 penalty of \$200.00	c Valve Insufficiency, neurysm, Chronic Obstructive a, lypertension, Hyperlipidemia, der and Cannabis Use he clients residing at this osis of Developmental left the facility without ust 19, 2022 and returned on he Director/Licensee and or failed to contact the police gust 21, 2022 to report client staff (#1 and #2) who worked failed to have documentation First Aid, client specific needs, ictive intervention and tions and Seclusion, Physical tion time-out. The Program ualified Professional also had of training in Alternatives to tions and Seclusion, Physical cion time-out. Either the r Program Coordinator was uring all staff trainings were nel records included the ation that training was dication Administration 1 and FC #5 were not kept off misplaced the 2nd page to for client #1 which listed				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED	
		IDENTIFICATION NOMBER.	A. BUILDING:				
		MHL032-498	B. WING		R 08/24/2022		
IAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE			
IELODY	HOUSE#1, LLC		ARWOOD DF	RIVE			
			, NC 27707				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLE DATE	
V 536	Continued From pa	ige 35	V 536				
	27E .0107 Client R Int.	ights - Training on Alt to Rest.	V 536				
	practices that empl to restrictive interver (b) Prior to providin disabilities, staff ind employees, studen demonstrate comp completing training other strategies for which the likelihood or injury to a person property damage is (c) Provider agence based on state com compliance and de gathered. (d) The training sha include measurable measurable testing behavior) on those methods to determ course. (e) Formal refresh by each service pro annually). (f) Content of the t provider wishes to the Division of MH/ Paragraph (g) of th (g) Staff shall dem following core area	D RESTRICTIVE implement policies and nasize the use of alternatives entions. Ing services to people with cluding service providers, ts or volunteers, shall etence by successfully in communication skills and creating an environment in d of imminent danger of abuse in with disabilities or others or a prevented. ies shall establish training inpetencies, monitor for internal monstrate they acted on data all be competency-based, e learning objectives, (written and by observation of objectives and measurable ine passing or failing the er training must be completed ovider periodically (minimum raining that the service employ must be approved by DD/SAS pursuant to is Rule. onstrate competence in the s: e and understanding of the					

PREFIX (EACH DEFIC	IER STREET AL STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	A. BUILDING:	PROVIDER'S PLAN OF CORRECTIO	(X3) DATE S COMPLI R 08/24	
MELODY HOUSE#1, LLC (X4) ID SUMMAR PREFIX (EACH DEFIC	IER STREET AL 3116 CEL DURHAN STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	DARESS, CITY, S DARWOOD DF I, NC 27707	PROVIDER'S PLAN OF CORRECTIO		/2022
MELODY HOUSE#1, LLC (X4) ID SUMMAR PREFIX (EACH DEFIC	3116 CEE DURHAN STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ARWOOD DF I, NC 27707	PROVIDER'S PLAN OF CORRECTIO		
(X4) ID SUMMAR PREFIX (EACH DEFIC	DURHAN STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	I, NC 27707	PROVIDER'S PLAN OF CORRECTIO		
(X4) ID SUMMAR PREFIX (EACH DEFIC	STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFIX			
PREFIX (EACH DEFIC	ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFIX			
		1/10	(EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETE DATE
V 536 Continued From	n page 36	V 536			
 (2) recognised and the second sectors (3) recognised and the second sector sector sect	hizing and interpreting human hizing the effect of internal and ors that may affect people with gies for building positive th persons with disabilities; hizing cultural, environmental and actors that may affect people with hizing the importance of and person's involvement in making their life; n assessing individual risk for vior; unication strategies for defusing ng potentially dangerous behavior; the behavioral supports (providing le with disabilities to choose directly oppose or replace n are unsafe). viders shall maintain of initial and refresher training for tars. nentation shall include: articipated in the training and the s/fail); and where they attended; and ctor's name; ivision of MH/DD/SAS may his documentation at any time. ualifications and Training the shall demonstrate competence of on testing in a training program ting, reducing and eliminating the ive interventions. the shall demonstrate competence				

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SU	
ND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLE	TED
		MHL032-498	B. WING		R 08/24/	2022
IAME OF F	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
	HOUSE#1, LLC	3116 CEI	DARWOOD DR	IVE		
	10032#1, 220	DURHAN	I, NC 27707			
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF (EACH CORRECTIVE AC		(X5) COMPLET
PREFIX TAG		SC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO	THE APPROPRIATE	DATE
V 536	Continued From pa	ge 37	V 536			
	by scoring a passin	g grade on testing in an				
	instructor training p	rogram.				
	(3) The traini	ng shall be				
		, include measurable learning				
		able testing (written and by				
	observation of behavior) on those objectives and					
	measurable methods to determine passing or failing the course.					
		ent of the instructor training the				
	service provider plans to employ shall be		Ŧ			
	approved by the Division of MH/DD/SAS pursuant		t			
	to Subparagraph (i)(5) of this Rule.		-			
	(5) Acceptable instructor training programs					
		e not limited to presentation of	:			
	()	ding the adult learner;				
	()	for teaching content of the				
	course;	for a secolar sting of the size of a				
	(C) methods performance; and	for evaluating trainee				
		ation procedures.				
		shall have coached experience				
		program aimed at preventing,				
		hating the need for restrictive				
	0	st one time, with positive				
	review by the coach					
		shall teach a training program				
		, reducing and eliminating the				
		interventions at least once				
	annually.	hall complete a refrecher				
		shall complete a refresher t least every two years.				
	(j) Service provider					
		nitial and refresher instructor				
	training for at least					
		mentation shall include:				
		pipated in the training and the				
	outcomes (pass/fail	l);				
		where attended; and				
	(C) instructor					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
	or contraction	BERTH TO/ THOM NOMBER.	A. BUILDING:			
М		MHL032-498	B. WING	B. WING		R 24/2022
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
IELODY	'HOUSE#1, LLC		DARWOOD DF /I, NC 27707	RIVE		
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PRÉFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLE DATE
V 536	Continued From pa	ge 38	V 536			
	request and review (k) Qualifications of (1) Coaches requirements as a f (2) Coaches the course which is (3) Coaches competence by con train-the-trainer inst	shall meet all preparation rainer. shall teach at least three times being coached. shall demonstrate npletion of coaching or				
	facility failed to ens (#1, #2, Program C Professional) had to alternatives to restr findings are: Review on 8/23/22	views and interviews, the ure four of four audited staff oordinator and Qualified raining on the use of ictive interventions. The of the facility's personnel				
	records revealed th Staff #1: -No date of hire. -Hired as a Habilita -National Crisis Inte					
	completed on 7/29/ -No documentation	() C				
	Staff #2:					

STATE FORM

IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA				E SURVEY PLETED
OF CONNECTION	IDENTIFICATION NOMBER.	A. BUILDING:			
	MHL032-498	B. WING		R 08/24/2022	
PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
HOUSE#1. LLC			RIVE		
-		M, NC 27707			
(EACH DEFICIENC)	MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETI DATE
Continued From pa	ge 39	V 536			
-NCI + training was -No documentation	completed on 7/29/21. of current training on the use				
-Date of hire was 9, -NCI+ training was -No documentation	/20/20. completed on 7/29/21. of current training on the use				
-Date of hire was 5, -NCI+ training was -No documentation	/6/15. completed on 10/2/20. of current training on the use				
revealed: -She was employed 2 years.	d with the facility for a little ove				
-She left the agency returned to the facil -She had NCI+ train	y in December 2021 and ity in April 2022. ning, she thought the training				
Coordinator reveale -It was her respons to ensure staff rece -She was responsib training in NCI+. -The Director/Licen	ed: ibility as Program Coordinator ived the required trainings. ble for ensuring staff had				
	OF CORRECTION PROVIDER OR SUPPLIER HOUSE#1, LLC SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From pa -No date of hire. -Hired as a Habilita -NCI + training was -No documentation of alternatives to re Program Coordinat -Date of hire was 9, -NCI+ training was -No documentation of alternatives to re Qualified Professio -Date of hire was 5, -NCI+ training was -No documentation of alternatives to re Qualified Professio -Date of hire was 5, -NCI+ training was -No documentation of alternatives to re Interviews on 8/22/2 revealed: -She was employed 2 years. -She thought they of ago. Interview on 8/23/2 -She left the agency returned to the facil -She had NCI+ train was completed a fe Interview on 8/23/2 Coordinator reveale -It was her responsit training in NCI+. -The Director/Licen trainings for staff.	OF CORRECTION IDENTIFICATION NUMBER: MHL032-498 PROVIDER OR SUPPLIER STREET A A116 CE DURHAI SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 39 -No date of hire. -Hired as a Habilitation Technician. -NCI + training was completed on 7/29/21. -No documentation of current training on the use of alternatives to restrictive interventions. Program Coordinator: -Date of hire was 9/20/20. -NCI+ training was completed on 7/29/21. -No documentation of current training on the use of alternatives to restrictive interventions. Qualified Professional: -Date of hire was 5/6/15. -NCI+ training was completed on 10/2/20. -No documentation of current training on the use of alternatives to restrictive interventions. Qualified Professional: -Date of hire was 5/6/15. -NCI+ training was completed on 10/2/20. -No documentation of current training on the use of alternatives to restrictive interventions. Interviews on 8/22/22 and 8/24/22 with staff #1 revealed: -She was employed with the facility for a little ove 2 years. -She hought they did NCI+ training a few months ago. -She hought they did NCI+ training a few months ago. Interview on 8/23/22 with staff #2 revealed: -She had NCI+ training, sh	OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING:	OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: MHL032-498 B. WING 'ROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 'HOUSE#1, LLC 3116 CEDARWOOD DRIVE DURHAM, NC 27707 SUMMARY STATEMENT OF DEFICIENCES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREVIDERS PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC Continued From page 39 V 536 -No date of hire.	OF CORRECTION IDENTIFICATION NUMBER: A BUILDING: 000000000000000000000000000000000000

	of Health Service Re					
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED
MHL032-498		MHL032-498	B. WING		R 08/24/2022	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
MELODY	HOUSE#1, LLC		DARWOOD DR I, NC 27707	RIVE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y 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 THE APPROPRIATE	(X5) COMPLETE DATE
V 536	Continued From pa	ge 40	V 536			
	schedule those train	act information. nsee] will not let any one else nings, she does it all herself." ff did the NCI+ training a few				
	Director/Licensee re- -The agency used N alternatives to restr -The Program Coor ensuring staff were -She thought all sta however she could certificates for staff -She confirmed the training on the use interventions for staff	NCI+ for training on the use of ictive interventions. rdinator was responsible for scheduled for NCI+ training. ff did a recent NCI+ training, not locate the training				
	NCAC 27G .5601 S	ross referenced into 10A SCOPE (V289) for a Type B Just be corrected within 45				
V 537	27E .0108 Client Ri ITO	ghts - Training in Sec Rest &	V 537			
	ISOLATION TIME-((a) Seclusion, physical time-out may be end to be and the competence in the to these procedures staff authorized to end to be a staff authorized to be a staff authorized to end to be a staff authorized to	SICAL RESTRAINT AND DUT sical restraint and isolation poloyed only by staff who have ave demonstrated proper use of and alternatives s. Facilities shall ensure that employ and terminate these ained and have demonstrated				

Division	of Health Service Re	aulation			FORM	APPROVED
STATEMEN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	СОМІ	E SURVEY PLETED
		MHL032-498	B. WING		R 08/24/20	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
	(HOUSE#1, LLC		ARWOOD D	RIVE		
MELOD	1100002#1, 220	DURHAM	, NC 27707			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
V 537	Continued From pa	ge 41	V 537			
Division of H	disabilities whose tr includes restrictive is service providers, e volunteers shall cor seclusion, physical and shall not use th training is complete demonstrated. (c) A pre-requisite to demonstrating com training in preventing the need for restrict (d) The training sha include measurable measurable testing behavior) on those methods to determi course. (e) Formal refreshe by each service pro- annually). (f) Content of the tr provider plans to en- the Division of MH/I Paragraph (g) of thi (g) Acceptable train but are not limited to (1) refresher the use of restrictive (2) guidelines (understanding imm others); (3) emphasis rights and dignity of concepts of least re- incremental steps in	Il be competency-based, e learning objectives, (written and by observation of objectives and measurable ne passing or failing the er training must be completed wider periodically (minimum raining that the service nploy must be approved by DD/SAS pursuant to s Rule. hing programs shall include, o, presentation of: information on alternatives to e interventions; s on when to intervene hinent danger to self and on safety and respect for the fall persons involved (using estrictive interventions and h an intervention); for the safe implementation				

Division	of Health Service Re	aulation			FORMA	PPROVED
STATEME	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S COMPL	
		MHL032-498	B. WING		R 08/24	/2022
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	TATE, ZIP CODE		
		3116 CEI		live		
MELOD	Y HOUSE#1, LLC	DURHAN	I, NC 27707			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
V 537	Continued From pa	ge 42	V 537			
	 (5) the use of interventions which assessment and mapsychological well-tuse of restraint thromosolity interventions which assessment and mapsychological well-tuse of restraint thromosolity intervention (6) prohibited (7) debriefing importance and pure (8) documentation of in at least three years (1) Document (A) who partice outcomes (pass/fail (B) when and (C) instructor (2) The Division review/request this (i) Instructor Qualific Requirements: (1) Trainers as by scoring 100% or aimed at preventing need for restrictive (2) Trainers as by scoring a passing instructor training p (4) The trainic competency-based objectives, measure observation of behavior and solation of b	f emergency safety include continuous onitoring of the physical and being of the client and the safe oughout the duration of the on; I procedures; I strategies, including their pose; and tation methods/procedures. rs shall maintain nitial and refresher training for tation shall include: tipated in the training and the I); I where they attended; and 's name. ion of MH/DD/SAS may documentation at any time. ication and Training shall demonstrate competence in testing in a training program g, reducing and eliminating the interventions. shall demonstrate competence in testing in a training program seclusion, physical restraint out. shall demonstrate competence g grade on testing in an				

	of Health Service Re	(X1) PROVIDER/SUPPLIER/CLIA		CONSTRUCTION		E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:				PLETED
		MHL032-498	B. WING		R 08/24/2022	
AME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
IELODY	(HOUSE#1, LLC	DURHAN	I, NC 27707			
(X4) ID			ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLET DATE
V 537	Continued From pa	ge 43	V 537			
	(5) The conte	ent of the instructor training the				
		ins to employ shall be				
		vision of MH/DD/SAS pursuant	t			
	to Subparagraph (j)					
		e instructor training programs				
	-	ot be limited to, presentation				
	of: (A) understan	ding the adult learner;				
		for teaching content of the				
	course;					
	(C) evaluation of trainee performance; and					
	(D) documentation procedures.					
	(7) Trainers shall be retrained at least					
	annually and demonstrate competence in the use					
		al restraint and isolation				
	time-out, as specific Rule.	ed in Paragraph (a) of this				
		hall be currently trained in				
		hall have coached experience				
		of restrictive interventions at				
	least two times with coach.	a positive review by the				
		shall teach a program on the				
		erventions at least once				
	annually.					
		hall complete a refresher				
	(k) Service provide	t least every two years.				
		nitial and refresher instructor				
	training for at least					
		tation shall include:				
	· · /	ipated in the training and the				
	outcome (pass/fail)					
	(B) when and	where they attended; and				
	(C) instructor					
		ion of MH/DD/SAS may				
		documentation at any time.				
	Qualifications of	Coaches:				

STATEMENT O AND PLAN OF	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	СОМ	E SURVEY PLETED
		MHL032-498	B. WING			R 24/2022
NAME OF PRO	VIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	TATE, ZIP CODE		
MELODY HO	DUSE#1, LLC		DARWOOD DR I, NC 27707	RIVE		
(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 THE APPROPRIATE	(X5) COMPLET DATE
V 537 Co	ontinued From pa	ge 44	V 537			
(2 tin (3 cc tra (m	quirements as a t) Coaches nes, the course w) Coaches ompetence by cor ain-the-trainer inst	shall teach at least three /hich is being coached. shall demonstrate npletion of coaching or truction. n shall be the same				
Ba fa (# Pr ph	ased on record re cility failed to ens 1, #2, Program C ofessional) had ti	et as evidenced by: views and interviews, the ure four of four audited staff oordinator and Qualified raining in the use of seclusion, and isolation time-out training.				
	eview on 8/23/22 cords revealed th	of the facility's personnel e following:				
-N -H -N tra -N of	aining was comple lo documentation	ervention + (NCI+) Defensive				
-N -H -N 7//	29/21.	tion Technician. aining was completed on of current training in the use				

STATE FORM

UXL211

If continuation sheet 45 of 47

Division	of Health Service Re	egulation			FORM	APPROVED
STATEMEN	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
MHL03		MHL032-498	B. WING			R 24/2022
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
	Y HOUSE#1, LLC	3116 CED	ARWOOD DI	RIVE		
MILLOD	T 110000E#1, EE0	DURHAM	, NC 27707			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
V 537	Continued From pa	ge 45	V 537			
	of seclusion, physic time-out.	al restraints and isolation				
	7/29/21. -No documentation					
		/6/15. of training in the use of restraints and isolation				
	revealed: -She was employed 2 years.	22 and 8/24/22 with staff #1 d with the facility for a little over lid NCI+ training a few months				
	-She left the agence returned to the facil	ning, she thought the training				
	to ensure staff rece -She was responsit training in NCI+. -The Director/Licen trainings for staff.	ed: ibility as Program Coordinator vived the required trainings. ble for ensuring staff had see scheduled all of the				
ivision of H	-She didn't know ar those trainer's cont lealth Service Regulation	ny trainers or have any of act information.				

Division of Health Service Regulation STATE FORM

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY PLETED
			A. BUILDING:		R	
		MHL032-498	B. WING			24/2022
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
MELODY	' HOUSE#1, LLC		DARWOOD DR M, NC 27707	RIVE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 537	Continued From pa	age 46	V 537			
	schedule those tra -She thought all sta months ago. Interviews on 8/23/ Director/Licensee r -The agency used seclusion, physical time-out. -The Program Coo ensuring staff were	ensee] will not let any one else inings, she does it all herself." aff did the NCI+ training a few /22 and 8/24/22 with the revealed: NCI+ for training in the use of restraints and isolation ardinator was responsible for e scheduled for NCI+ training. aff did a recent NCI+ training,				
	however she could certificates for staff -She confirmed the training in the use of and isolation time-of Program Coordinat This deficiency is c	not locate the training				
		nust be corrected within 45				