Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND FLAN	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING:		COMPLETED	
		MHL0411086	B. WING		C 10/04/2022	
NAME OF P	ROVIDER OR SUPPLIER		RESS, CITY, STA	TE, ZIP CODE	10/0 // 2022	
		4214 BEEC	HWOOD DRIV	E, SUITE 110		
LINDLEY	COLLEGE I		ORO, NC 2741	•		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
V 000	INITIAL COMMENTS		V 000			
	A complaint survey was completed on 10/4/22. The complaint was unsubstantiated (intake #NC00191574). Deficiencies were cited.					
This facility is licensed for the following service category: 10A NCAC 27G .5400 Day Activity for Individuals of All Disability Groups						
		d for 0 and currently has a rvey sample consisted of ents.				
V 108	27G .0202 (F-I) Perso	onnel Requirements	V 108			
	10A NCAC 27G .0202 PERSONNEL REQUIREMENTS (f) Continuing education shall be documented. (g) Employee training programs shall be provided and, at a minimum, shall consist of the following:					
	delineated in 10A NC 10A NCAC 26B;	rights and confidentiality as AC 27C, 27D, 27E, 27F and				
	client as specified in t	the mh/dd/sa needs of the the treatment/habilitation				
	plan; and (4) training in infection bloodborne pathogen					
	.5602(b) of this Subcl	ed under 10a NCAC 27G napter, at least one staff				
	times when a client is member shall be trair					
		nagement, currently trained				
	to provide cardiopulm	onary resuscitation and				
		h maneuver or other first aid nose provided by Red Cross, ssociation or their				
			<u> </u>			

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

(X6) DATE TITLE

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN	PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING:			COMPLETED		
		MHL0411086	B. WING		C 10/04/2022	
NAME OF D	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE 710 CODE	10/04/2022	
NAME OF P	ROVIDER OR SUPPLIER			•		
LINDLEY	COLLEGE I		CHWOOD DRIV ORO, NC 274			
()(1) ID	SLIMMARY ST.	ATEMENT OF DEFICIENCIES	T	PROVIDER'S PLAN OF CORRECTIO	N OVE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE	
V 108	Continued From page	9 1	V 108			
	equivalence for reliev (i) The governing bodimplement policies ar reporting, investigatin	ing airway obstruction.				
	facility failed to ensur- meet the mh/dd/sa ne specified in the treatn 3 audited staff (#5 an Review on 9/29/22 of - Hire Date: 5/13/22	iew and interviews, the e staff completed training to				
	Review on 9/29/22 of - Hire Date: 11/27/17	staff #32's record revealed:				
	- Admission date: 5/1 - Diagnoses: Chiari M Cataract; Bilateral De Malfunction; Chromos Moderate Intellectual - Review of client #7's Competencies" revea "Transfers/Carries/Mo plate in the back of hi	Malformation; Congenital afness; CIQ Kidney some Imbalance; and Disability s "Consumer Specific				

Division of Health Service Regulation

STATE FORM 6899 EROM11 If continuation sheet 2 of 6

Division of Health Service Regulation

DIVISION	n nealth Service Negu	lation				
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUM		IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
				C		
MHL0411086		B. WING		10/04/2022		
NAME OF D	DOVIDED OD CUDDUED	CTDEET AS	DDECC CITY CTA	TE 710 000E		
NAME OF PI	ROVIDER OR SUPPLIER		DRESS, CITY, STA			
LINDLEY	COLLEGE I		CHWOOD DRIV	•		
		GREENS	BORO, NC 2741	10		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	-	(X5)
PRÉFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE	RIATE	DATE
				DEFICIENCY)		
V 108	Continued From page	2	V 108			
* 100	Continued i form page	, _	1			
	Interview on 9/27/22 v	with client #7's legal				
	guardian revealed:	•				
	•	ds and a plate in the back of				
	his head and neck.	as and a plate in the basis of				
		rom birth and has a cataract				
		mpacts his vision. Client #7				
		- 'E'				
	is unable to have surgery to remove the cataract.					
	- "He has to bend at his waist to look down. He can't turn his head left to right or right to left, he					
		•				
	nas to turn his whole	body to look left and right."				
	lt:	.:				
	Interview on 9/28/22 with staff #32 revealed:					
		r for the van client #7 rode in				
	the mornings.					
	- Client #7 had no mo					
	- She did not know ab	-				
	issues/medical diagno	oses for client #7.				
	Interview on 9/28/22 v	with staff #5 revealed:				
	 - He was the driver for the van client #7 rode in the mornings. - He was not aware of any mobility issues for 					
	client #7.	rany mobility issues for				
	- He did not know about any medical					
	issues/medical diagno	,				
	issues/medical diagno	oses for client #7.				
	Interviews on 0/20/22	and 10/4/22 with the Area				
	Director revealed:	and 10/7/22 Willi life Alea				
		cific Competencies were				
	kept in a locked box of					
	- Staff #32 and staff #5 do not provide a "billable					
	-	uld not see the client specific				
		completing their notes.				
		bout medical issues they				
	can't see."					
V 112	27G .0205 (C-D)		V 112			
	Assessment/Treatme	nt/Habilitation Plan				

Division of Health Service Regulation

STATE FORM 6899 EROM11 If continuation sheet 3 of 6

Division of Health Service Regulation

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		MHL0411086	B. WING		10	C 0/ 04/2022	
	ROVIDER OR SUPPLIER	4214 BE	ADDRESS, CITY, STATE ECHWOOD DRIVE, SBORO, NC 27410	SUITE 110			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
V 112	10A NCAC 27G .020 TREATMENT/HABIL PLAN (c) The plan shall be assessment, and in legally responsible p of admission for clier receive services bey (d) The plan shall in (1) client outcome(sachieved by provision projected date of active active date of active as staff responsible (4) a schedule for rannually in consultative responsible person (5) basis for evaluation outcome achieveme (6) written consent responsible party, or	25 ASSESSMENT AND LITATION OR SERVICE The developed based on the partnership with the client or person or both, within 30 days and the service and 30 days. The developed based on the person or both, within 30 days and the service and 30 days. The developed based on the person or both; The developed based on the partnership with the client or legally or both; The developed based on the partnership with the client or legally or both; The developed based on the partnership with the client or legally or both; The developed based on the partnership with the client or legally or both; The developed based on the partnership with the client or legally or both;	V 112				
	facility staff failed to treatment/habilitation	t as evidenced by: riews and interviews, the implement strategies in the n plan to address the needs f 2 audited clients (#7). The					

Division of Health Service Regulation

STATE FORM 6899 EROM11 If continuation sheet 4 of 6

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			
MHL0411086		B. WING		C 10/04/2022		
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
LINDLEY	COLLEGE I		HWOOD DRIV			
			ORO, NC 2741			
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
V 112	Continued From page	÷ 4	V 112			
	- Admission date: 5/1 - Diagnoses: Chiari M Cataract; Bilateral De Malfunction; Chromos Moderate Intellectual - Review of client #7's dated 5/1/22 revealed program is working w available to him at all (American Sign Lang) with his communication beneficial for his transinteractions in the cor	Malformation; Congenital afness; CIQ Kidney some Imbalance; and Disability s Individual Support Plan d: "Having a 1:1 at the day ell for him. Having someone times that knows ASL uage) and can assist him on needs. 1:1 has been sportation needs and mmunity as well."				
	Interviews on 9/27/22 and 10/3/22 with client #7's legal guardian revealed: - Client #7, who had bilateral deafness, did not have a 1:1 on the van who could sign for him. - She had requested if a sign language interpreter could not be on the van that client #7 be able to facetime with a sign language interpreter. "That was never made available." - "He has been there for over 5 years. I have always requested that (sign language interpreter) for [client #7]. That he have someone to communicate with him."					
	revealed: - The facility had adveinterpreter position which client #7 The treatment plant because no one had alanguage interpreter p	position. for after 7/25/22 incident but				

Division of Health Service Regulation

STATE FORM 6899 EROM11 If continuation sheet 5 of 6

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE COMF	(X3) DATE SURVEY COMPLETED		
						С		
		MHL0411086	B. WING		10	/04/2022		
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STAT					
LINDLEY	LINDLEY COLLEGE I 4214 BEECHWOOD DRIVE, SUITE 110 GREENSBORO, NC 27410							
240.15	CLIMMADV CT				F CORRECTION	0.5		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OI (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE		

Division of Health Service Regulation

STATE FORM 6899 EROM11 If continuation sheet 6 of 6