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	MHL034-324	A. BUILDING: _____ B. WING _____	R 08/05/2022

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SHARPE AND WILLIAMS #3	4419 CANAAN PLACE WINSTON-SALEM, NC 27105

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{V 000}	INITIAL COMMENTS A follow up survey was completed on August 5, 2022. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600A Supervised Living for Adults with Mental Illness. This facility is licensed for 6 and currently has a census of 6. The survey sample consisted of audits of 3 current clients.	{V 000}		
V 110	27G .0204 Training/Supervision Paraprofessionals 10A NCAC 27G .0204 COMPETENCIES AND SUPERVISION OF PARAPROFESSIONALS (a) There shall be no privileging requirements for paraprofessionals. (b) Paraprofessionals shall be supervised by an associate professional or by a qualified professional as specified in Rule .0104 of this Subchapter. (c) Paraprofessionals shall demonstrate knowledge, skills and abilities required by the population served. (d) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence. (e) Competence shall be demonstrated by exhibiting core skills including: (1) technical knowledge; (2) cultural awareness; (3) analytical skills; (4) decision-making; (5) interpersonal skills; (6) communication skills; and (7) clinical skills. (f) The governing body for each facility shall	V 110		

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V 110	Continued From page 1 develop and implement policies and procedures for the initiation of the individualized supervision plan upon hiring each paraprofessional. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, 1 of 2 staff (In-House Manager (IHM)) failed to demonstrate the knowledge, skills and abilities required for the population served. The findings are: Reviews on 8/3/22 and 8/4/22 of IHM's record revealed: -A hire date of 2/25/21 -A job description of Paraprofessional -A training form, dated 4/4/22 at 11:00am, and signed by IHM and Qualified Professional #1 (QP #1) revealed: -"[QP #1] met with [IHM] on April 4, 2022 at 11:00am and reiterated and explained the importance of staying awake and alert in the homes during her shift. [QP #1] explained to [IHM] the sleep hours while on shift and the staff should not be lying down during the shift if it is not their break time. [IHM] ensured [QP #1] the importance of staying alert while on shift and stated, 'it will not happen again'. If [IHM] feels she was getting burned out while on shift, she will inform [QP #1] and [HR (Human Resources)] supervisor for coverage. If [IHM] is seen lying down during her shift, not alert, and it is not on their break time there will be an immediate write-up and one-week suspension."	V 110		

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V 110	Continued From page 2 Review on 8/3/22 of client #3's record revealed: -An admission date of 10/7/21 -Diagnoses of Schizoaffective Disorder, Bipolar Disorder, a History of Using Methamphetamines, and a History of Post-Traumatic Stress Disorder (PTSD) Review on 8/3/22 of client #4's record revealed: -An admission date of 9/3/15 -Diagnoses of Schizoaffective Disorder, Hearing Loss, Bipolar Disorder, Hypertension, Hyperlipidemia and Diabetes Review on 8/3/22 of client #5's record revealed: -An admission date of 8/1/22 -Diagnoses of Schizophrenia, Asthma and Hypertension -An assessment dated 8/1/22 noted "was admitted from [a psychiatric hospital], has poor insight and impaired judgment, required heightened monitoring, has disorganized thought process at times, currently denies any suicidal or homicidal ideation and auditory hallucinations." Observations on 8/2/22 of the inside of the facility from approximately 8:48am to 9:15am revealed: -Client #2 answered the facility door and identified herself as staff -Began to mop up excess water from the kitchen floor and stated "there's a leak somewhere." -The IHM was sitting upright on the sofa with two pillows -Her (the IHM) eyes were closed -Client #2 walked over to the IHM and reported "the State is here." -IHM would not respond to her name being called several times by client #2 -The IHM briefly opened her eyes, smiled and closed her eyes again -Client #4 walked outside to smoke a cigarette	V 110		

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V 110	Continued From page 3 -Client #1 was asleep, client #2 was mopping the kitchen floor, client #3 was in her room, client #4 was on the front porch smoking, client #5 was sitting in a chair in the living room and client #6 had left for the day program -There was no other staff at the facility Further observations and interviews on 8/2/22 from 9:16am to 10:06am revealed: -The Medication Technician Supervisor (MTS) arrived with medication from the pharmacy -Confirmed the IHM was the assigned awake staff -Called the IHM's name several times before she answered -At 9:40am, the Associate Professional Assistant (APA) arrived at the facility -He called the IHM's name in a loud voice, (approximately 18 inches from her head) -The IHM woke up and sat on the edge of the sofa -At 9:42am, the IHM got up from the sofa and went into the kitchen Interview on 8/2/22 with client #1 revealed: -The IHM sleeps all the time in the mornings -"She stays up late." Observation and interview on 8/2/22 at 8:55am, with client #2 revealed: -The IHM had taken some pain medication (for her back) -"The medicine she takes for her back, puts her out just like that (snapped her fingers)...she is supposed to be awake, but she stayed awake last night. She (the IHM) used to work at [a sister facility] ...it is really hard to wake her up some mornings ..." Interview on 8/2/22 with client #3 was not	V 110		

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V 110	Continued From page 4 successful as she was unable to answer questions due to her inability to communicate Interview on 8/2/22 with client #4 revealed: -"I refuse to answer any questions on the grounds that it may incriminate me ..." Interview on 8/2/22 with client #5 revealed: -"It was barely daylight when I woke up this morning. [IHM] was sleeping on the sofa ..." Interview on 8/3/22 with client #6 revealed: -The IHM falls asleep "all the time" on the sofa -"She got suspended yesterday (8/2/22) for sleeping ...all I know is that she is supposed to be awake (on her shift) ..." Interview on 8/2/22 with the IHM revealed: -Previously worked at a sister facility -Started working at this facility approximately 2 months ago -Had gotten client #6 up on 8/2/22 -Prepared client #6's breakfast and packed her lunch before she left for the day program (around 8:15am) -"After [client #6] leaves, everyone goes back to bed ...I had been up and I was so tired, I laid back own and fell asleep ...". -Acknowledged she was the only staff at the facility and was to be awake on her shift Interview on 8/2/22 with the APA revealed: -Had a lot of concerns when he learned the IHM was asleep on her shift -"The clients need supervision while they are in the facility ...we have a coachable moment now and we will have a meeting to address this and implement some steps to prevent this from reoccurring ...there will be write up documentation and disciplinary action ...we are taking her off the	V 110		

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V 110	Continued From page 5 schedule for two weeks ..." Interview on 8/2/22 with the Qualified Professional #1 revealed: -Had concerns the IHM was asleep with clients present -"She is not being able to respond quick enough to meet the needs of the clients. She's not monitoring or supervising the clients. Staff should have been up and awake. We are actually going to address that issue ...we have contacted another staff to come in and work the shift ...she will be suspended for two weeks ...we have scheduled a meeting for next Tuesday (8/9/22) to meet with her and go over our expectations and discussing what occurred. We will be retraining her before we bring her back in ..." Attempted interview on 8/5/22 with the Qualified Professional #2/Chief Executive Officer/Licensee/Registered Nurse was unsuccessful as the telephone call was not returned. Review on 8/5/22 of the facility's plan of protection, dated 8/5/22 and written by the QP #1 revealed: -"What immediate action will the facility take to ensure the safety of the consumers in your care? On 08/02/2022, we immediately suspended the staff for two weeks. We will immediately meet and retrain the staff on her job duties and being awake and alert in the home. -Describe your plans to make sure the above happens. We will immediately (08/05/2022) discuss pop-up visits in the morning." The six clients' diagnoses included Schizophrenia, Asthma and Hypertension, Dementia, Morbid Obesity, Non-Insulin	V 110		

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V 110	Continued From page 6 Dependent Diabetes, Localized Edema, Insomnia, Bipolar Disorder, a History of Using Methamphetamines, a History of Post-Traumatic Stress Disorder (PTSD), Hearing Loss and Hyperlipidemia. Three of the clients (#3, #4 and #5) required supervision while in the facility. On 8/2/22, from 8:48am to 9:35am, the IHM was observed sleeping on the sofa while 5 of the 6 clients were present. Client #5 needed heightened supervision due to her history of suicidal and homicidal ideation. Client #2 attempted to wake up staff. When upper management arrived at the facility, the IHM continued to sleep and was not easily aroused by loud voices calling her name or when she was tapped on the shoulder. The IHM stated she was tired and that was why she had fallen back to sleep. This deficiency constitutes a Type B rule violation which is detrimental to the health, safety and welfare of the clients. If the violation is not corrected within 45 days, an administrative penalty of $200.00 per day will be imposed for each day the facility is out of compliance beyond the 45th day.	V 110		
{V 736}	27G .0303(c) Facility and Grounds Maintenance 10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS (c) Each facility and its grounds shall be maintained in a safe, clean, attractive and orderly manner and shall be kept free from offensive odor. This Rule is not met as evidenced by:	{V 736}		

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{V 736}	Continued From page 7 Based on observations and interviews, the facility was not maintained in a safe, clean, orderly and attractive manner. The findings are: Observations on 8/2/22 from 9:51am to 10:18am, of the inside of the facility revealed: -Client #2 was mopping up excessive water in the kitchen -The sofa in the living room sagged when sat on by both staff and clients -A handwritten sign on the outside of the clients' hallway bathroom -The sign stated, "do not use toilet." -The toilet would attempt to flush, but the water was clogged -A shower chair was sitting near the wall with scraped paint on the drywall approximately 2 1/2 feet long at the height of the shower chair's seat bolts -The shared closet in client #3 and client #6's bedroom had items piled up on her dresser, a bag of trash hung off the dresser knob, numerous pairs of shoes were stacked at the foot of the bed, there was a hamper overflowing with dirty clothes and clothing was on the closet floor -The bathroom in client #3 and client #6's bedroom had broken towel holders -There was a patched wall on the right side of the bathroom vanity that needed to be painted -The kitchen sink had dirty pots and dishes in it -In client #2 and client #5's bedroom, client #2 had numerous folded clothing stacked around -Client #2's armoire had a broken shelf and items were crammed into where the shelf was supposed to be hung -Client #5's clothing was stacked on the dresser and there was clothing in the corner of the room -On client #5's bed, there was a dirty sheet balled up on the bed -The blinds on the left window in client #2 and	{V 736}		

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{V 736}	Continued From page 8 #5's bedroom was bent Further observations on 8/3/22 at 3:35pm of the inside of the facility revealed: -A ring around the hallway bathroom's tub -Water would not drain in the bathroom tub -In client #3 and client #6's bathroom, the shower liner had a black like substance on it -The toilet seat in the bathroom was loose Interview on 8/2/22 with client #1 revealed: -The toilet in the hallway was stopped up -Was not sure how long the toilet had been that way -"You can only do #1 in that bathroom. I have to walk through the other bedroom to do #2. I don't like walking through someone's room." -Has not seen the maintenance man come out -Had not sat on the sofa in the living room -"I don't sit there because the sofa is too low ..." Interview on 8/3/22 with client #2 revealed: -There was a problem with the clients' hallway bathroom tub -"It won't drain properly ...there's always 3 to 4 inches of water left in it ..." Interview on 8/2/22 with client #3 was not successful as she was unable to answer questions due to her diagnoses. Interview on 8/2/22 with client #4 revealed: -"I refuse to answer any questions on the grounds that it may incriminate me ..." Interview on 8/2/22 with client #5 revealed: -"I haven't used the front bathroom, but the one in the back is good. Staff told me the bathroom toilet was stopped up." -"You can't get up off the sofa because it sags,	{V 736}		

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{V 736}	Continued From page 9 and I am short. So, I have been sitting in the living room chair." -Had turned off the kitchen sink's faucet because water was all over the kitchen floor -"There was water everywhere! You don't think when you walk into the kitchen that there would be water standing in it ...it is dangerous because someone could have slipped and fell ..." Interview on 8/3/22 with client #6 revealed: -The sofa needed to be replaced -Was not sure how long the hallway bathroom's toilet had been stopped up -The other clients in the facility used the bathroom in the room she shared with client #3 -"Our toilet seat is loose in there ..." Interview on 8/2/22 with the In-House Manager (IHM) revealed: -There was not a leak in the kitchen -"Someone left the kitchen sink running. I am not sure who did it ..." -Had placed the sign outside the hallway bathroom on 7/30/22 -"It won't flush and gets clogged. Someone put a whole roll of toilet tissue in it this morning. I had to mop up all the water around the toilet early this morning. This is not the first time the toilet has been stopped up. I heard someone threw either an apple or an orange in it before ..." -A repair man had fixed the toilet after that incident -Had made upper management aware the toilet was not working properly during the morning meeting (8/2/22) -Stated the living room sofa needed to be replaced -"It has been like that since I started working here (approximately 2 months) ..."	{V 736}		

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{V 736}	Continued From page 10 Interview on 8/3/22 with staff #2 revealed: -No one had come to fix the hallway bathroom's toilet -"It takes a while for them (upper management) to fix things ..." -Took a shower last night (8/2/22) in the hallway bathroom -"I noticed right away the water was not draining ...water was all the way up to that black ring (in the tub) ..." -There was an issue with the toilet in client #3 and client #6's bathroom -"I just noticed the toilet seat is not attached ...I made them (upper management) aware this morning (8/3/22) in our computer notes ..." Interview on 8/2/22 with the Associate Professional Assistant (APA) revealed: -When he arrived at the facility this morning (8/2/22), the kitchen was in "disarray" -"The toilet issue was reported last Friday, (7/29/22) because it was stopped up. We have a maintenance person. The clients are currently using the other toilet in the facility ..." -Would ensure the maintenance man came out today (8/2/22) to look at the toilet -The sofa was supposed to have already been repaired -"I can't defend it (the sofa not being repaired.) The house was pressure washed. The grass was cut every other week. I wish I could give you a logical explanation, but I can't ..." Interview on 8/2/22 with the Qualified Professional #1 revealed: -She had been over to the facility on a weekend -Had cleaned the facility -"I even dusted off the ceiling fans, personally." -The Qualified Professional #2/Chief Executive Officer/Licensee/Registered Nurse (QP	{V 736}		

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{V 736}	Continued From page 11 #2/CEO/L/RN) would have to answer the question as to why repairs had not been made to the facility Attempted interview on 8/5/22 with the QP#2/CEO/L/RN was unsuccessful as the telephone call was not returned. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	{V 736}		
V9999	Final Observations Based on observation, record review and interview the facility failed to follow North Carolina General Statute (NCGS) 122C and admitted one client (#5) while a Suspension of Admission (SOA) was in place. The findings are: Per NCGS 122C-23(g) Article 2, licensure of Facilities for the Mentally Ill Developmentally Disabled, and Substance Abuses. The Secretary may suspend the admission of any new clients to a facility licensed under this Article where the conditions of the facility are detrimental to the health or safety of the clients This suspension shall be for the period determined by the Secretary and shall remain in effect until the Secretary is satisfied that conditions or circumstances merit removal of the suspensions Observation and interview on 8/2/22 at 8:48am with client #5 revealed: -Client #5 came out of a bedroom -Sat down on a chair in the living room and stated "I came here yesterday (8/1/22) afternoon ..." Review on 8/5/22 of the facility's public record maintained by the Division of Health Service	V9999		

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V9999	Continued From page 12 Regulation (DHSR) revealed the following: -The license capacity was 6 -A SOA letter dated 6/10/22 with "effective immediately" documented Review on 8/2/22 of client #5's record revealed: -An admission date of 8/1/22 Interview on 8/5/22 with the Qualified Professional #1 revealed: -Client #5 had been hospitalized for suicidal ideation -Was not aware a SOA was in place for the facility Attempted interview on 8/5/22 with the Qualified Professional #2/Chief Executive Officer/Licensee/Registered Nurse was unsuccessful as the telephone call was not returned	V9999		