Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED. A. BUILDING: B WNG MHL034-336 09/20/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 719 INLAND DRIVE HOME CARE SOLUTIONS AT INLAND DRIVE KERNERSVILLE, NC 27284 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X4) ID (X5)(EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) V 000 INITIAL COMMENTS V 000 An annual, complaint and follow up survey was completed on 9/20/22. The complaint was substantiated (Intake # NC189834). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised DHSR - Mental Health Living for Adults with Developmental Disabilities. NOV 0 4 2022 This facility is licensed for 3 and currently has a census of 1. The survey sample consisted of audits of 1 current client. Lic. & Cert. Section V 107 V 107 27G .0202 (A-E) Personnel Requirements Staff files are kept on 10A NCAC 27G .0202 PERSONNEL Site at the main office. REQUIREMENTS They are kept in the file (a) All facilities shall have a written job description for the director and each staff position which: room behind double lock (1) specifies the minimum level of education, competency, work experience and other qualifications for the position; (2) specifies the duties and responsibilities of Explanation: we had recently the position; (3) is signed by the staff member and the had a we review. There were supervisor; and (4) is retained in the staff member's file. a couple of tites that had (b) All facilities shall ensure that the director, each staff member or any other person who been misplaced. Those files provides care or services to clients on behalf of the facility: (1) is at least 18 years of age; have since been located. (2) is able to read, write, understand and follow directions: (3) meets the minimum level of education, competency, work experience, skills and other qualifications for the position; and (4) has no substantiated findings of abuse or

Division of Health Service Regulation

LABORATORY DIRECTOR

SIGNATURE

reder TITLE

(X6) DATE

10-17-22

Division of	f Health Service Regu	lation	(X2) MI II TIPI E	CONSTRUCTION	(X3) DATE SURVEY	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		COMPLETED	
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V 107	neglect listed on the Personnel Registry. (c) All facilities or se applicants for emplo conviction. The imp decision regarding e upon the offense in which the applicant (d) Staff of a facility currently licensed, r accordance with ap services provided. (e) A file shall be memployed indicating	North Carolina Health Care ervices shall require that all yment disclose any criminal act of this information on a employment shall be based relationship to the job for is applying. or a service shall be egistered or certified in plicable state laws for the maintained for each individual of the position, including	V 107	files are reviewed or as often as needed.  All files will be con after training and file room. If file removed for any interview, audits, up they should be ret	ed.  Implehed  Stored in  les are  reason  odates)	
*	Based on record refacility failed to maincluded the requirement other qualifications (staff #1). The find Review on 9/20/22 revealed no persoreview for staff #1	of facility personnel records nnel record was available for		Immediately.  Files should be after new time to quarterly and as as needed to ens campleteness.  The trainer is responsible for quarterly and and the fills. The Direct responsible for quarterly and audits.	aining; often swe consible reviewn; tar 15	

-He has worked for the facility about three years on third shift and his hours are 11pm to 8am and

División of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
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NAME OF F	PROVIDER OR SUPPLIER	STREET	DDRESS, CITY,	STATE, ZIP CODE			
HOME CA	ARE SOLUTIONS AT INLA	ND DRIVE 719 INL	AND DRIVE				
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V 107	Continued From page 2		V 107				
	8pm to 8am every oth	er weekend					
	Interviews on 9/20/22 with the Residential Manager, the Qualified Professional, and the Associate Professional revealed staff # 1 had a personnel record but none of them had access to the record. The record was locked in the Owners office, they don't have keys to the office.						
V 108	27G .0202 (F-I) Person	nnel Requirements	V 108				
i t t t	V 108  27G .0202 (F-I) Personnel Requirements  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: (1) general organizational orientation; (2) training on client rights and confidentiality as delineated in 10A NCAC 27C, 27D, 27E, 27F and 10A NCAC 26B; (3) training to meet the mh/dd/sa needs of the client as specified in the treatment/habilitation plan; and (4) training in infectious diseases and bloodborne pathogens. (h) Except as permitted under 10a NCAC 27G .5602(b) of this Subchapter, at least one staff member shall be available in the facility at all times when a client is present. That staff member shall be trained in basic first aid including seizure management, currently trained to provide cardiopulmonary resuscitation and trained in the Heimlich maneuver or other first aid techniques such as those provided by Red Cross, the American Heart Association or their equivalence for relieving airway obstruction. (i) The governing body shall develop and implement policies and procedures for identifying,						

					FORM APPROVED
	f Health Service Regu	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:	COMPLETED		
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V 108	Continued From pag		35. 632.5		
	and communicable	ing and controlling infectious diseases of personnel and			
	clients.				
	This Rule is not me	at as evidenced by:		All of CC II by trai	ned
	Based on record re-	views and interviews, the		All staff will be train to meet the moldals	rea
1 *	facility failed to ensu	ure 3 of 5 audited staff (staff		to meet the mhldals	a necas
	#1, the Residential	Manager (RM), and the ned to meet the mh/dd/sa		nf the clients as specia	fical m
	needs of the client	as specified in the		the treatment I rehability	tation
	treatment/habilitation	on plan. The findings are:		plan.	
	Review on 9/20/22	of facility personnel records		plat.	e not
	revealed no record	for staff #1, the RM, and the		If an individual does have this specific trained !!	nie.
	co-owner personne	t mh/dd/sa training was		have this specific train	ming.
	completed.			the will be trained/	re-trained
	Interview on 9/20/2	2 with the Associate		and the information as	lded to
	Professional (AP) r	evealed:		the file. Arecord of	this
	- He was unsure w	hether the RM, the co-owner, npleted the mh/dd/sa training;		the tile. Arecord of	1 - 11
	- He was not respo	onsible for mh/dd/sa training.		Should be maintained	of in the
	- He was unsure of	f who was responsible for		employee file.	
	mh/dd/sa training.			Chiplogue see.	
		22 with the Qualified		in a se manda	1 at time
	Professional revea	iled: whether the RM, the co-owner,		The training is provided	to de to d
	or staff #1 had cor	npleted the mh/dd/sa training;		of hire and annually	upaana.
	-The AP was respond	onsible for ensuring staff had		The designated Trainer	is responsible
	completed mh/dd/	sa training.		The designated Transcr for this. The Director	or will
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				minitar to make st	ve ir is

PRINTED: 10/04/2022 FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING: \_ COMPLETED R MHL034-336 B. WING 09/20/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 719 INLAND DRIVE HOME CARE SOLUTIONS AT INLAND DRIVE KERNERSVILLE, NC 27284 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRFFIX (X5) COMPLETE **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) V 118 | Continued From page 4 V 118 Complete. V 118 27G .0209 (C) Medication Requirements V 118 The munitoring will take place quarkerly or as often as needed. 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (c) Medication administration: (1) Prescription or non-prescription drugs shall only be administered to a client on the written order of a person authorized by law to prescribe drugs. (2) Medications shall be self-administered by clients only when authorized in writing by the client's physician. (3) Medications, including injections, shall be administered only by licensed persons, or by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer medications. (4) A Medication Administration Record (MAR) of all drugs administered to each client must be kept current. Medications administered shall be recorded immediately after administration. The MAR is to include the following: (A) client's name: (B) name, strength, and quantity of the drug; (C) instructions for administering the drug; (D) date and time the drug is administered; and (E) name or initials of person administering the drug. (5) Client requests for medication changes or checks shall be recorded and kept with the MAR file followed up by appointment or consultation with a physician.

This Rule is not met as evidenced by:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  MHL034-336  MHL034-336  STREET ADDRESS, CITY, STATE, ZIP CODE T19 INLAND DRIVE  SIJMANARY STATEMENT OF PRECIDENCIES (EACH CORRECTION STATEMENT OF PRECIDENCIES) (EACH CORRECTION ACTION SHOULD BE CROSS REFERENCED TO THE APPROPRIATE COMPANY (EACH CORRECTION ACTION SHOULD BE CROSS REFERENCED TO THE APPROPRIATE COMPANY (EACH CORRECTION ACTION SHOULD BE CROSS REFERENCED TO THE APPROPRIATE COMPANY (EACH CORRECTION ACTION SHOULD BE CROSS REFERENCED TO THE APPROPRIATE COMPANY (EACH CORRECTION ACTION SHOULD BE CROSS REFERENCED TO THE APPROPRIATE COMPANY (EACH CORRECTION ACTION SHOULD BE CROSS REFERENCED TO THE APPROPRIATE COMPANY (EACH CORRECTION ACTION SHOULD BE CROSS REFERENCED TO THE APPROPRIATE COMPANY (EACH CORRECTION ACTION SHOULD BE CROSS REFERENCED TO THE APPROPRIATE (EACH CORRECTION ACTION SHOULD BE CROSS REFERENCED TO THE APPROPRIATE (EACH CORRECTION ACTION SHOULD BE CROSS REFERENCED TO THE APPROPRIATE (EACH CORRECTION ACTION SHOULD BE CROSS REFERENCED TO THE APPROPRIATE (EACH CORRECTION ACTION SHOULD BE CROSS REFERENCED TO THE APPROPRIATE (EACH CORRECTION ACTION SHOULD BE CROSS REFERENCED TO THE APPROPRIATE (EACH CORRECTION ACTION SHOULD BE CROSS REFERENCED TO THE APPROPRIATE (EACH CORRECTION ACTION SHOULD BE CROSS REFERENCED TO THE APPROPRIATE (EACH CORRECTION ACTION SHOULD BE CROSS REFERENCED TO THE APPROPRIATE (EACH CORRECTION ACTION AC	Division of	Health Service Regu	ulation			(X3) DATE SURVEY
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-11/3/2022 Melatonin (sleep aid) 5 milligram, take  mm4hy by the Nurse ₹ QP			anno dailu:		at the name and	A THOM WOLLD
1 tablet by mouth in the evening at 9 pm.		tablet by mouth of	onin (sleep aid) 5 milligram, take		minishly by the NU	urse & QP
		1 tablet by mouth	in the evening at 9 pm.		before thing.	
Boylow on 9/19/2022 of client #1's MARs for the					perce time.	

month of September 2022 revealed:

STATEMEN	n of Health Service Regu INT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TIPLE CONSTRUCTION	(X3) DATE	CI IDI/EV
Elit Marc 1 m	OF CONTROL HOLY	IDENTIFICATION NUMBER:	A. BUILDIN	NG:		PLETED
		MHL034-336	B. WING_		1	R
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE	09/	20/2022
	ARE SOLUTIONS AT INLA		AND DRIVE	STATE, ZIP CODE		
		KERNE	RSVILLE, NC	27284		
(X4) ID PREFIX	SUMMARY ST/ (EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECT	CTION	(X5)
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR	OULD RE	COMPLETE
				DEFICIENCY)	COPRIATE	DAIL
V 118	Continued From page	∌ 6	V 118	The mandant of mak	ho.	
	- Loratadine was only	documented as being		The residential man		8
	administered on 9/2/22	22;		been notified to inc	crease	
	- Triamcinolone was a	applied daily except for the		reviews of the mares		
	mornings of 9/1/22, 9/3 9/16/22 and the	3/22, 9/4/22, 9/14/22,				290
		9/6/22, 9/8/22, and 9/14/22;		Contact the nurse ( )	ire dor as	8
	<ul> <li>Levothyroxine and Vi</li> </ul>	/itamin D3 were not				1 -
1	documented as being	administered on 9/16/22:		soon as an error ha	is been	
	- Docusate Sodium wa	as not documented as		found		
	being administered the	e morning of 9/16/22; e was not documented as		,		
	being administered on	e was not documented as the mornings of 9/11/22,		This process is inguing Ensure that medicate administered as ord	of to	
	9/13/22, 9/15/22, and	the mornings of ar Thez,		" + md. a.d	I.mc are	
	9/16/22;			ensure that meaning	aris we	-
	- Docusate Sodium and	nd Quetiapine Fumarate		as classed as a second		
	were not documented a evenings of 9/4/22,	as being administered the		administrey as ora	lerea.	
	9/6/22, 9/8/22, and 9/	/14/22-				
	- Lamotrigine and Mela	atonin were not				
	documented as being a	administered on 9/4/22.				
1	9/6/22, 9/8/22, and 9/14	4/22.				
	Review on 9/20/22 of cl	lient #1's MARs for the				
1	months of July and Aug	gust 2022 revealed that				
-	Triamcinolone was appl	olied daily. (Even though				
t	the medication expired	on 6/28/22.)				
1	Observation on 9/19/22	2 @ 4:12 pm of client #1's				
r	medications on hand rev	evealed:				
-	-Loratadine was not ava	ailable;				
-	-Triamcinolone expired of	on 6/28/22.				
1	Interview on 9/20/22 with	th staff #1 revealed he				
W	was unaware he failed to	to document that the	1			
r	medications were not ad	dministered	1		,	

Interview on 9/19/22 with the Associate

documented as being administered;

-He was unsure why the medications were not

Professional revealed:

Division of Health Service Regulation (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: A. BUILDING: AND PLAN OF CORRECTION R 09/20/2022 B. WING MHL034-336 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 719 INLAND DRIVE HOME CARE SOLUTIONS AT INLAND DRIVE KERNERSVILLE, NC 27284 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL CROSS-REFERENCED TO THE APPROPRIATE DATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) V 118 Continued From page 7 V 118 -Staff should have documented on the back of the MARs the reason the medications were not administered. Interview on 9/20/2022 with the Residential Manager (RM) revealed: -She was unsure of why the medications were not documented as being administered; -Staff #1 was responsible for administering medications in the mornings and she would need to write up staff #1; -Had no prior knowledge of the Loratadine not being administered and the Triamcinolone being expired; -Was having trouble with getting staff to document when medications were administered; Reviewed the MARs monthly. Interview on 9/20/22 with the Qualified Professional revealed: -She contacted the pharmacy on 9/20/22 and was waiting on a telephone call from the pharmacy to reorder Loratadine and Triamcinolone; -She, the RM, and staff were responsible for the -Staff were to notify the RM about any concerns with medications. V 736 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.

Division of Health Service Regulation STATE FORM

PRINTED: 10/04/2022 FORM APPROVED Division of Health Service Regulation (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: R R WNG MHL034-336 09/20/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 719 INLAND DRIVE HOME CARE SOLUTIONS AT INLAND DRIVE KERNERSVILLE, NC 27284 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) V 736 V 736 Continued From page 8 This Rule is not met as evidenced by: Based on observations and interviews, the facility The co-owner is staff failed to ensure the facility and its grounds responsible for were maintained in a safe, clean, attractive, and orderly manner. The findings are: lawn maintenance. Observations on 9/19/22 from 1:30 pm until 1:45 The lawn maintenance has been delegated to pm of the outside of the facility revealed: -The shrubs on the front of the facility were overgrown, one shrub with briars extended onto the front porch; a 3rd party. There is a bi-weekly grass cutting -A sectional couch, a mattress, box spring, a gray tote, and white clothes basket with pillows/clothing covered with mold under the carport; -A mattress and box spring propped against the Schedule. facility; -Bee/Wasp's nests on the front porch and over the maintenance of the the ramp to the side door; -The storage building was covered with yards will be monitored on a overgrown shrubs. Interview on 9/19/22 with Client #1 revealed the mattress, box spring, gray tote, and white clothes bi-Welky schedule as well The schedule was implemented basket was under the carport and had been there since he moved into the facility (7/12/18).

Division of Health Service Regulation

basket before.

facility/grounds;

Interview on 9/19/22 with the Associate Professional revealed he does not work at the facility that often and did not recall seeing the mattress, box spring, gray tote, and white clothes

Interview on 9/19/22 with the Co-owner revealed: -He was responsible for the upkeep of the

-Has a company to cut the grass every two weeks

Division of Health Service Regulation		(X2) MULTIPLE Co	ONETRICTION	(X3) DATE S	(X3) DATE SURVEY			
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SU					COMPLETED	
AND PLAN O	FCORRECTION	IDENTIFICATIO	ON NOWIBER.	A. BUILDING:				
					R			
		MHL034-3	136	B. WING		09/2	09/20/2022	
		WITEOUT						
NAME OF PE	ROVIDER OR SUPPLIER		STREETA	DDRESS, CITY, STATE	E, ZIP CODE			
			719 INLA	ND DRIVE				
HOME CA	RE SOLUTIONS AT INL	AND DRIVE		RSVILLE, NC 2728	4			
					PROVIDER'S PLAN OF C	ORRECTION	(X5)	
(X4) ID	SUMMARY S	TATEMENT OF DEFIC BY MUST BE PRECED	IENCIES DED BY FULL	ID PREFIX	(FACH CORRECTIVE ACTIO	N SHOULD BE	COMPLETE DATE	
PREFIX	REGULATORY OR	LSC IDENTIFYING IN	FORMATION)	TAG	CROSS-REFERENCED TO TH		DATE	
TAG	NEOOD WOLLD				DEFICIENCY	)		
				14726				
V 736	Continued From pag	je 9		V 736				
	and complete other	duties to the land	decane as					
		udiles to the land	accape do					
	requested; -The mattress, box s	pring and other	items were					
	outside to be picked	spring and outer	tem nick III.					
	outside to be picked	dow that the item	e would be					
	-Was unsure of the	uay mai me nem	is would be					
	picked up; -The various items h	and only boon of	iteide for					
	about two to three w	ad only been of	witched out					
	A CONTRACTOR OF THE PROPERTY O	eeks since he s	Witched out					
	the furniture.							
		oith the Qualifi	od					
		Interview on 9/20/22 with the Qualified						
	Professional revealed; -She visits the facility once a month and was last							
	-She visits the facili	ty once a month	and was last					
	at the facility on the	28th of August,	r the corport					
	-Did not see the var	nous items unde	e poods to the					
	bee/wasp's nest, or	the maintenant	e needs to the					
	grounds.							
	0.000.00	0	avaalad:					
	Interview on 9/20/2	2 With Stall #1 it	evealed.					
	-He did not know h	ow long the valid	Jus items were					
	under the carport;		the cornert:					
	-Had seen the varie	ous items under	ne carport,					
	-Had not observed the maintenance needs of the facility/grounds or the bee/wasp's nest because							
	facility/grounds or t	ne bee/wasps n	lest pecause					
	when		ighttimo:					
	he arrives to the f	acility it's dark/ni	ignitime,					
1	-"The bushes are k	kinda long and i	loid life					
	owners."							
			d deficiency					
	This deficiency cor	nstitutes a re-cité	ed deficiency					
	and must be corrected within 30 days.							
1								