Division of Health Service Regulation

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
ANDIEAN			A. BUILDING:		OOWI LI	_1_0
		MHL023-048	B. WING		01/1	9/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
CHARLES	ROAD A	829-1 CHAF SHELBY, N	RLES ROAD A C 28152	ı		
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
V 000	INITIAL COMMENTS		V 000			
	An annual survey was completed on January 19, 2023. A deficiency was cited.  This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disability.  This facility is licensed for 3 and currently has a census of 3. The survey sample consisted of audits of 3 current clients.  This facility is located in the same building as two sister facilities. The sister facilities will be identified as sister facility B and sister facility C. Sister facility staff and clients will be identified using the letter of the facility and a numerical identifier.					
V 290	of this Rule shall be denable staff to responneeds.  (b) A minimum of one present at all times we premises, except whe habilitation plan docucapable of remaining without supervision. as needed but not less the client continues to the home or commun specified periods of ticc) Staff shall be presented.	above the minimum Paragraphs (b), (c) and (d) determined by the facility to ad to individualized client  e staff member shall be hen any adult client is on the en the client's treatment or ments that the client is in the home or community The plan shall be reviewed as than annually to ensure to be capable of remaining in ity without supervision for me. sent in a facility in the atios when more than one	V 290			

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		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN OF CORRECTION IDENTIFIC		IDENTIFICATION NUMBER:	A. BUILDING:			
MHL023-048		B. WING		04/40/0000		
		WITILU23-U48			01/1	9/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		829-1 CH/	ARLES ROAD A			
CHARLES	ROAD A	SHELBY.	NC 28152			
040.15	STIMMADA ST	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTION	NI .	0/5)
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
TAG	`	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE		DATE
				DEFICIENCY)		
V 290	Continued From page	e 1	V 290			
	(1) children or a	adolescents with substance				
	` '	be served with a minimum				
		or every five or fewer minor				
		vever, only one staff need be				
		ng hours if specified by the				
		procedures determined by				
	the governing body; of					
		adolescents with				
		ilities shall be served with				
	I	every one to three clients				
		present for every four or				
	l -	However, only one staff				
	need be present durir					
	-	rgency back-up procedures				
	determined by the go					
		serve clients whose primary				
		ce abuse dependency:				
	_	staff member who is on				
	\ /	in alcohol and other drug				
	withdrawal symptoms					
		ons to alcohol and other				
	drug addiction; and					
	-	s of a certified substance				
	abuse counselor shal					
	as-needed basis for e	each client.				
	This Rule is not met	as evidenced by:				
	Based on interviews a	and record reviews, the				
	facility failed to mainta	ain one staff member				
	present at all times w	hen an adult client was on				
	the premises affecting	g 3 of 3 clients (Clients #1,				
	#2, and #3). The find	lings are:				
	Review of Client #1's	record revealed:				
	-Date of Admission: 8					
	-Age:79 years old.					
		e Intellectual Developmental				

Division of Health Service Regulation

STATE FORM 6899 BEWY11 If continuation sheet 2 of 9

Division of	Division of Health Service Regulation					
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		MHL023-048	B. WING		01/19/2023	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	ITE, ZIP CODE		
CHARLES	S ROAD A		ARLES ROAD A NC 28152			
(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 APPROPE DEFICIENCY)	BE COMPLETE	
V 290	Disability, Hypertensic-Treatment plan dated assessment which de capability for unsuper Review of Client #2's -Date of Admission: 9 -Age: 69 years oldDiagnosis: Severe In DisabilityTreatment plan dated assessment which de capability for unsuper Review of Client #3's -Date of Admission: 4 -Age: 53 years oldDiagnoses: Major De Intellectual Developm -Treatment plan dated assessment which de capability for unsuper Review on 1-13-23 of November and Decerlin November 2022 that the facility every dated as the facility every da	on. d 12-22-22 did not have an etermined the clients vised time.  record revealed: -9-09.  Itellectual Developmental dd 4-1-22 did not have an etermined the clients vised time.  record revealed: -29-11.  Pepressive Disorder, Mild lental Disability, Autism. dd 2-24-22 did not have an etermined the clients vised time.  Itel facility client census for mober 2022 revealed: lere were at least two clients ay.  lere was at least one client ay.	V 290			
	revealed: -During the week, see	•				

Division of Health Service Regulation

revealed:

scheduled to arrive between 2:30 pm - 4 pm. -Clients would return home from work/day

Review on 1-12-23 and 1-17-23 of time sheets and census for November and December 2022

program at approximately 4 pm.

STATE FORM BEWY11 If continuation sheet 3 of 9

Division of	<u>of Health Service Regu</u>	lation				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
			·			
			B. WING			
		MHL023-048	B. WING		01/19/2023	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ODRESS, CITY, STA	ATE, ZIP CODE		
		829-1 CF	ARLES ROAD A	A		
CHARLES	ROAD A		NC 28152			
	CLIMMADY CT			DDOV/DEDIS DI ANI OF CORDECTIO	N O(E)	
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD	( - /	
TAG			TAG	CROSS-REFERENCED TO THE APPROP		
				DEFICIENCY)		
V 290	Continued From page	3	V 290			
V 250	Continued From page	<del>-</del> 3	V 230			
	-November 2022: 10	of 30 days where at some				
	point there was not a	staff person present while				
	clients were present.					
	•	m midnight until the clients				
		ram (approximately 8 am).				
	7. 0	no staff between 8:02 pm -				
	8:29 pm.	·				
		) Staff #1 clocked out at				
	,	ocked back in at 1:00 am.				
		Staff #1 clocked out at 11:59				
	,	. Staff #1 clocked back in at				
		ocked in from 11:13 pm -				
	11:15 pm.	oned in noin 11.10 pin				
		) no staff between 7:08 pm -				
	8:41 pm.	, ne etan between 1.00 pm				
		etween 10:04 pm - 11:05 pm.				
		etween 9:04 pm - midnight.				
		etween midnight - 7:44 am.				
		7 pm and midnight. Staff #3				
		t did not clock out. 9.75				
	hours were document	ted but unable to determine				
	which hours were wo					
		) no staff between midnight -				
		tween 8:24 pm - midnight.				
		8 am but did not clock out.				
	13 hours were docum	nented but unable to				
	determine which hour					
	-11-27 (Sunday)	no staff between midnight -				
	8:58 am.	<u>.</u>				
		out of 31 days where at				
		not a staff person present				
	while clients were pre	·				
	•	tween 8:10 pm - 8:30 pm.				
		tween 9:08 pm - 10:14 pm.				
		no staff between 9:10 am -				
	9:39 am.	no stan bottoon of to am -				
		etween 10:25 pm - 10:55				
	pm.	55511 10.25 pin - 10.00				

Division of Health Service Regulation

-12-23 no staff between 8:36 pm - midnight. Staff #3 clocked in at 8 am but did not clock out.

STATE FORM 6899 BEWY11 If continuation sheet 4 of 9

Division of Health Service Regulation						
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		MHL023-048	B. WING		01/19/2023	
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	ODRESS, CITY, STA	TE, ZIP CODE		
CHARLES	POAD A	829-1 CH	ARLES ROAD A			
OHARLES	, ROAD A	SHELBY	, NC 28152			
(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 290	Continued From page	<del>.</del> 4	V 290			
	7:57 am.  -12-25 (Sunday) 3:03 pm and no staff in midnight.  -12-26 no staff between  -12-28 no staff between  -12-28 no staff between  -12-31 (Saturday) 11:30 am.  Interview on 1-10-23 and the regarding staffing path Interview on 1-10-23 and the regarding staff staff would always be sister facilities.  Interview on 1-9-23 and the regarding staff staf	s were worked. ) no staff between midnight - no staff between 9:48 am - between 10:06 pm - etween midnight - 9:00 am. 9:21 pm - 9:30 pm. etween 10:02 pm - 10:13 ) no staff between 9:07 am - with Client #1 revealed: and difficult to communicate or information from Client #1 terns/issues. with Client #2 revealed: due to being nonverbal. with Client #3 revealed: e nearby in one of the other with Staff #2 revealed: arles Road A but had cilities B and C at the same				
		the time." (Covering Charles				

Division of Health Service Regulation

time).

Road A and Sister Facilities B and C at the same

-Would go from apartment to apartment (between Charles Road A to Sister Facilities B and C) to

make sure they have what they need.
-When covering for Charles Road A, would

STATE FORM BEWY11 If continuation sheet 5 of 9

PRINTED: 01/30/2023

Division (	of Health Service Regu	lation			FORM	1 APPROVED	
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 SURVEY COMPLETED	
		MHL023-048	B. WING		01/1	9/2023	
NAME OF P	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE						
CHARLES	S ROAD A		ARLES ROAD A NC 28152				
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE		BE	(X5) COMPLETE DATE			
V 290	complete most tasks can't function like the -"I can pretty much hat three facilities at once Interview on 1-17-23 -"We have been short	there. "They are older and ones (clients) in B and C." andle it by myself." (cover all	V 290				

Interview on 1-11-23 with the Staff House Manager revealed:

-The clients very seldom have negative

behaviors.

-"She just runs back and forth the whole time she is here." (when covering for all facilities at once)

Interview on 1-10-23 with Staff #B1 revealed:
-"[Staff #1] works the whole building sometime."
(Charles Road A and Sister Facilities B and C)

Interview on 1-9-23, 1-10-23 and 1-11-23 with the

Qualified Professional (QP) revealed:
-Since being employed, Sister Facility B and
Sister Facility C always had one staff. One staff
covered both facilities at the same time.
-The clients in Sister Facility B and Sister Facility
C were more independent and only one staff
worked to cover both facilities.
-Was trained by the previous QP and " ...I was
told it was in their plans they could stay
independently for 2 hours in B and C."

-"Recently there has been situations where we had one staff for the whole facility (Charles Road A and Sister Facilities B and C) ...We are just short staffed right now."
-Clients would arrive home from work/day

program around 4 pm.

-"If someone doesn't show, I'll ask if they (staff going off shift) can stay a few minutes. I will come

Division of Health Service Regulation

STATE FORM 6899 BEWY11 If continuation sheet 6 of 9

Division of	Division of Health Service Regulation						
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION		SURVEY ETED	
			A. BUILDING: _				
		MUU 000 040	B. WING		04/4	0/0000	
		MHL023-048		<del></del>	01/1	9/2023	
NAME OF PR	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE			
CHARLES	ROAD A		ARLES ROAD A	L			
		SHELBY,	NC 28152				
(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 CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE	
V 290	Continued From page	e 6	V 290				
	if I can't find someone Sometimes I can find can't."  -The last two months with having just one serical and can't.  -The last two months with having just one serical and contains a lot of staff. Lost a lot of staff Interview on 1-11-23 services Regional Direll and contains a lot of staff Interview on 1-11-23 services Regional Direll and contains a lot of staff Interview and staffing isself and contains a lot of staff Interview and staffing isself Interview on 1-17-23 services and the contains a lot of staff Interview on 1-17-23 services (CEO) revealed and contains a lot of staff Interview and trying to a lot of staff Interview and try	e until I can find someone. someone, sometimes I  have been more frequent staff cover all three facilities. ger and then a third shift of 3 months ago."  with the Community rector revealed: big issue, staffing during sues for all 3 facilities. hat there were not people croviding a dangerous suld run a whole lot better."  with the Chief Executive ed: ne way staff is right now, we be keep people safe." so a thoughtful process who so due to staffing." sware that had happened. to be addressed." (sharing so Road A and Sister					

Division of Health Service Regulation

Review on 1-13-23 of the Plan of Protection dated 1-13-23 written by the Community Services

"What immediate action will the facility take to ensure the safety of the consumers in your care? The facility will ensure that the staff schedule is maintained with a staff present for all individuals in Charles Road A at all times. This staff will not be used for staffing Charles Road B or C.

Regional Director revealed:

STATE FORM BEWY11 If continuation sheet 7 of 9

Division of Health Service Regulation						
STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED		
		_				
		B. WING				
	MHL023-048	B. WING	<del></del>	01/19/2023		
NAME OF PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE			
	829-1 CH	ARLES ROAD A	1			
CHARLES ROAD A	SHELBY	NC 28152				
(VA) ID SUMMARY STAT	TEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTIO	N (VE)	—	
()(1)(1)	MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD	()	E	
	C IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROP	RIATE DATE		
			DEFICIENCY)			
V 290 Continued From page	7	V 290				
	will be posted every two					
weeks in the facility to	ensure that staff know their					
time and place of work						
If a staff will not be able	e to work their schedule,					
then they will inform the	e 'Q' (QP) for the facility at					
least four hours before	the beginning of shift.					
The 'Q' will then ensure	e that a staff person is					
obtained for the vacant	t shift.					
The 'Q' will be respons	ible for ensuring that the					
Regional Director has a	a copy of the staffing					
schedule and is made	aware of any changes to					
the schedule.						
Describe your plans to	make sure the above					
happens.						
The Regional Manager	will check weekly with the					
supervising 'Q' to ensu	re that schedules have					
been followed.						
The Regional Manager	will also check with staff					
on shift at varying time:	s to ensure that two staff					
are present at all times	when individuals are					
present in the facilities.						
The facility served 3 ac	dult clients whose					
•	ellectual Developmental					
Disability, Hypertension						
Disorder, and Autism.	The facility was located in a					
building that was also o	occupied by Sister					
Facilities B and C. The	re were 10 days in					
November 2022 and 10	0 days in December 2022					
where at some point th	ere was not a staff present					
while clients were pres	ent. The clients required					
supervision and had no	ot been assessed or					
·	ised time. Staff from Sister					
Facilities B and/or C we						
	s present for Charles Road					
A. Staff that was assign	-					
	oad A would also work to					
_	ities B and C. Staff would					

Division of Health Service Regulation

cover these shifts ranging from minutes to several hours. This deficiency constitutes a Type

STATE FORM 6899 BEWY11 If continuation sheet 8 of 9

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	MHL023-048	B. WING		01/19/2023	
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
CHARLES ROAD A		ARLES ROAD A NC 28152	ı		
PREFIX (EACH DEFICIENCY MU	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
V 290 Continued From page 8  B rule violation which is of safety, and welfare of the not corrected within 45 dependity of \$200.00 per deeach day the facility is out the 45th day.	e clients. If the violation is ays, an administrative ay will be imposed for	V 290			

Division of Health Service Regulation

STATE FORM BEWY11 If continuation sheet 9 of 9