Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
AND FLAN	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING:		COMPLI	TIED	
		MHL023-155	B. WING		01/1	9/2023	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE			
CHARLES	ROAD C		RLES ROAD C	:			
		SHELBY, N	IC 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE	
V 000	INITIAL COMMENTS		V 000				
	An annual survey was completed on January 19, 2023. A deficiency was cited.						
	category: 10A NCAC	d for the following service 27G .5600C Supervised Developmental Disability.					
	This facility is licensed for 2 and currently has a census of 2. The survey sample consisted of audits of 2 current clients. This facility is located in the same building as two sister facilities. The sister facilities will be identified as sister facility A and sister facility B. Sister facility staff and clients will be identified using the letter of the facility and a numerical identifier.						
V 290	27G .5602 Supervise	d Living - Staff	V 290				
	of this Rule shall be of enable staff to responseeds. (b) A minimum of one present at all times we premises, except whe habilitation plan docu capable of remaining without supervision.						
	the client continues to the home or commun specified periods of ti (c) Staff shall be pres	o be capable of remaining in ity without supervision for me. sent in a facility in the atios when more than one					

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

(X6) DATE TITLE

Division of	of Health Service Regu	lation				
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		MHL023-155	B. WING		01/19/2023	
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STAT	E, ZIP CODE		
CHARLES	ROAD C		ARLES ROAD C NC 28152			
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
V 290	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 1 (1) children or adolescents with substance abuse disorders shall be served with a minimum of one staff present for every five or fewer minor clients present. However, only one staff need be present during sleeping hours if specified by the emergency back-up procedures determined by the governing body; or (2) children or adolescents with developmental disabilities shall be served with one staff present for every one to three clients present and two staff present for every four or more clients present. However, only one staff need be present during sleeping hours if specified by the emergency back-up procedures determined by the governing body. (d) In facilities which serve clients whose primary diagnosis is substance abuse dependency: (1) at least one staff member who is on duty shall be trained in alcohol and other drug withdrawal symptoms and symptoms of secondary complications to alcohol and other drug addiction; and (2) the services of a certified substance abuse counselor shall be available on an as-needed basis for each client.		V 290			
	facility failed to mainta present at all times w	and record reviews, the ain one staff member hen an adult client was on g 2 of 2 clients (Clients #1				
	Review of Client #1's -Date of Admission: 2 -Diagnoses: Mild Inte					

Division of Health Service Regulation

Disability and Schizophrenia.

STATE FORM 6899 3KHF11 If continuation sheet 2 of 10

Division of	<u>of Health Service Regu</u>	lation			
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		
		MHL023-155	B. WING		01/19/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ODRESS, CITY, STA	TE, ZIP CODE	
CHARLES	POADC	829-1 CH	ARLES ROAD C	;	
CHARLES	ROAD C	SHELBY	NC 28152		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	(* /
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	
IAG		,	IAG	DEFICIENCY)	
V 290	Continued From page	e 2	V 290		
	-Treatment plan dated	d 6-1-22 did not have an			
	assessment which de				
	capability for unsuper				
	Review of Client #2's	record revealed:			
	-Date of Admission: 1				
		e Intellectual Developmental			
	Disability.	·			
	-Treatment plan dated 11-1-22 did not have an				
	assessment which determined the clients				
	capability for unsuper	vised time.			
	Review on 1-13-23 of the facility client census for				
	November and Decer				
		ecember 2022 there was at			
	least one client at the	facility every day.			
	Review on 1-13-23 of revealed:	f a weekly schedule			
	-During the week, sec	cond shift staff were			
		etween 2:30 pm - 4 pm.			
	-Clients would return	•			
	program at approxima	ately 4 pm.			
		nd 1-17-23 of Time Sheets			
		ecember 2022 revealed:			
		of 30 days where a staff did			
		tire 24-hour workday for this			
		re present. During the nere was not a staff person			
	present while clients	•			
		were present. ween midnight to wake up			
		ily) and from 11:01 pm -			
	midnight.	,, and nom 11.01 pm -			
	•	ween midnight to wake up			
	and from 10:38 pm - i				
		ween midnight to wake up			

Division of Health Service Regulation

and from 9:17 pm - midnight.

9:36 am and from 8:56 pm - midnight.

-11-5 (Saturday) no staff between midnight to

STATE FORM 6899 If continuation sheet 3 of 10 3KHF11

Division of	of Health Service Regu	ılation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _	A. BUILDING:		TED
			_			
			B. WING			
		MHL023-155	B. WING		01/19	9/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	TE. ZIP CODE		
			IARLES ROAD C			
CHARLES	ROAD C					
		SHELBY	, NC 28152			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF		COMPLETE DATE
TAG	NEGOLATORI ORI	LOC IDENTIF FING HAT OLIVIATION,	TAG	DEFICIENCY)	NAIE	5/112
	 		+	·		
V 290	Continued From page	e 3	V 290			
		tween midnight to wake up				
		nidnight. This day Staff #1				
		rom 7:11 pm - 8:58 pm. No				
	staff clocked in for co	verage when clients				
	returned from work/da					
ļ		etween midnight to wake up				
	and from 10:47 pm -					
		etween midnight to wake up				
	and from 7:49 pm - m					
		/) no staff between midnight				
	to 8:26 and from 10:5	,				
		etween midnight to wake up				
	and from 11:05 pm - i					
		etween midnight to wake up				
	and from 11:16 pm - i					
		etween midnight to wake up				
	and from 11:19 pm - i					
		etween midnight to wake up				
	and from 10:55 pm -					
		locked in at 8 am but did not				
		ere documented but unable				
ļ	to determine which he					
	-11-29 Staff #1 c	locked in at 8 am but did not				
	clock out. 8 hours we	ere documented but unable				
	to determine which he	ours were worked.				
	-December 2022: 27	of 31 days where a staff did				
	not clock in for work f	for this facility and clients				
	present. During the re	emaining 4 days, there was				
		esent while clients were				
	present.					
	-12-8 no staff be	tween midnight to wake up				
	and from 4 pm - midn					
		tween midnight to wake up				
	and from 8:34 pm - m					
		etween midnight to wake up				
	and from 8:45 pm - m	•				
		etween midnight to wake up				
ļ	, and from 10:11 pm - i	midnight. Staff was clocked				

Division of Health Service Regulation

in from 5:12 pm - 10:11 pm. No staff clocked in for coverage when clients returned home from

STATE FORM 6899 If continuation sheet 4 of 10 3KHF11

Division of	<u>of Health Service Regu</u>	lation				
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
744512741	or dorate of the transfer of t	BENTI TO THOM NOMBER.	A. BUILDING: _			
		MHL023-155	B. WING		01/1	9/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STAT	E, ZIP CODE		
CHARLES	ROAD C		ARLES ROAD C			
OHARLE	TROAD 0	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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
V 290	Continued From page	÷ 4	V 290			
	work/day program.					
		with Client #1 revealed: th between Charles Road C Road C overnight.				
	-During the night, Sta watch it on our side."	with Client #2 revealed: If would watch tv "they Ild be in Sister Facility A at				
	-Staff would check in bouncing back and Road B and Sister Fa	forth." (between Charles cility C) ff stays in Charles Road C				
	-Had lived in Sister Fa -"Staff pops in and ou	check on us to see if we are				
	-The clients in Charle B were "pretty muc -Would go between C Facility B "back and -There had been only been here." (for Siste Facility C) -Would walk over and Sister Facility A. -"[Staff #A1] works the	harles Road C and Sister d forth all the time." "one staff as long as I have				

Division of Health Service Regulation

Interview on 1-11-23 with Staff #2 revealed:

STATE FORM STATE FORM SKHF11 If continuation sheet 5 of 10

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
MHL023-155		B. WING		01/19/2023	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
CHARLES	ROAD C		ARLES ROAD C		
		·	NC 28152		T
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC 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	e 5	V 290		
	-When working betwee Sister Facility B, would sure they were doing -Sister Facility B maint that they remained or -Would usually spend Charles Road C. Interview on 1-9-23 w -Mostly worked in Charles Road B and more independent"Mainly I sit with the I go back and forth ar Sister Facilities B and Interview on 1-12-23 -"I work by myself all Road C and Sister Facilities B and Charles Road A to Sismake sure they have -"I can pretty much have sure they have -"I can pretty much have facilities at once -"If I am by myself (co girls (Sister Facility B) stuff and chill." Interview on 1-17-23 -"We have been short-"I haven't done it in a facilities at once) -The clients very seld behaviors.	een Charles Road C and d go back and forth to make chores and hygiene. Illy required supervision so in task. If the majority of her time in with Staff #A2 revealed: In a receive a rec			
	Interview on 1-11-23 Manager revealed:	with the Staff #A House			

Division of Health Service Regulation

-One staff covered both Charles Road C and

STATE FORM STATE FORM SKHF11 If continuation sheet 6 of 10

Division of	of Health Service Regul	lation			TORWAITROVED
STATEMENT	OF DEFICIENCIES DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		MHL023-155	B. WING		01/19/2023
NAME OF PR	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	TE, ZIP CODE	
CHADIES	POADC	829-1 CH	IARLES ROAD C		
CHARLES	ROAD C	SHELBY	, NC 28152		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	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		V 290		
V 290	SHELBY, Note that the state of		V 290		
	Interview on 1-11-23 v Services Regional Dir -"I think it has been a				

Division of Health Service Regulation

working."

-Have had staffing issues for all 3 facilities.
-"I didn't understand that there were not people

-"I don't think we are providing a dangerous

STATE FORM STATE FORM SKHF11 If continuation sheet 7 of 10

Division of Health Service Regulation

Division o	of Health Service Regu	lation				
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE S	URVEY
	OF CORRECTION	IDENTIFICATION NUMBER:			COMPLI	
			A. BUILDING: _			
MHL023-155		B. WING		01/1	9/2023	
		WITE023-133			1 01/1	3/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		920.4.04	ARLES ROAD O			
CHARLES	ROAD C			•		
		SHELBY,	NC 28152			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE	RIATE	DATE
				DEFICIENCY)	ľ	
V 290	Continued From page	e 7	V 290		ľ	
		and all arrays are also be at the attentity			ľ	
	environment, but it co	ould run a whole lot better."			ľ	
					ļ	
	Interview on 1-17-23	with the Chief Executive			ļ	
	Officer (CEO) revealed	ed:			ľ	
	` '	the shared staff between the			ļ	
		rles Road C and Sister			ļ	
					ľ	
		we had the evaluations			ľ	
	(unsupervised time as	,			ļ	
	-"Unfortunately with t	he way staff is right now, we			ļ	
	are short and trying to	o keep people safe."			ľ	
		er put in anyone in those			ľ	
		Road C and Sister Facility			ľ	
		_			ľ	
	B) that couldn't handl				ļ	
		s a thoughtful process who			ļ	
	goes into those home	es due to staffing."			ľ	
	-"Honestly I was not a	aware that had happened.			ļ	
	That definitely needs	to be addressed." (sharing			ļ	
	staff between Charles	, ,			ľ	
	Facilities A and B)	Trodd o drid olotor			ļ	
	•				ľ	
	-"We definitely screw				ļ	
	documented what ne	eded to get documented."			ļ	
					ľ	
	Review on 1-13-23 of	f the Plan of Protection			ľ	
	dated 1-13-23 written	by the Community Services			ļ	
	Regional Director rev	•			ļ	
	5	on will the facility take to			ľ	
					ļ	
		he consumers in your care?			ļ	
	•	e that the staff schedule is			ļ	
	maintained with a sta	ff present for all individuals			ľ	
	in Charles Road B an	d C at all times. This staff			ľ	
	will not be used for st	affing Charles Road A.			ľ	
		will be posted every two			ľ	
					ľ	
	-	ensure that staff know their			ľ	
	time and place of wor					
	If a staff will not be ab	ole to work their schedule,				
	then they will inform t	he 'Q' (QP) for the facility at				
		e the beginning of shift.				
					ľ	
	The Q will then ensu	re that a staff person is				

Division of Health Service Regulation

obtained for the vacant shift.

The 'Q' will be responsible for ensuring that the

STATE FORM STATE FORM SKHF11 If continuation sheet 8 of 10

Division of Health Service Regulation

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
ANDILAN			A. BUILDING: _		OOWII EETED	
		MHL023-155	B. WING		01/19/2023	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
		829-1 CHA	RLES ROAD C			
CHARLES	ROAD C	SHELBY, N				
(V4) ID	SLIMMARY ST.	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTION	N (VE)	
(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 APPROPF DEFICIENCY)	BE COMPLETE	
V 290	Continued From page	e 8	V 290			
V 290	Regional Director has schedule and is made the schedule. Care Coordinators are contacted immediatel for unsupervised time. Care Coordinators wireview plans for all interest with unsupervised in order to refuse appropriate for each appropriate for each appropriate and ensure that it is reflect appropriate and ensure that it is reflect Describe your plans to happens. The Regional Manages supervising 'Q' to ensure that it is reflect Describe your plans to happens. The Regional Manages supervising 'Q' to ensure that all time present at all time present in the facilities. The facility served 2 and diagnoses included in Disability and Schizolocated in a building to Sister Facilities B and November 2022 and	s a copy of the staffing aware of any changes to ad guardians will be y to obtain a verbal consent of for these individuals in C. Il also be requested to dividuals in both Charles are that the treatment team rised time for individuals ents. The plan will then be alect approved unsupervised each individual. Risk to be reviewed in order to anount of supervision and the in the assessment. The plan will the earlier that schedules have the will check weekly with the sure that schedules have the rewill also check with staff es when individuals are s."	V 290			
	while clients were pre	esent. The clients required not assessed or approved				
	for unsupervised time A and/or B would cov	e. Staff from Sister Facilities er the lapse of time where				
	that was assigned an	for Charles Road C. Staff d clocked in as working for d also work to cover Sister				

Division of Health Service Regulation

STATE FORM STATE FORM If continuation sheet 9 of 10

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 SURV. COMPLETED				
		MHL023-155	B. WING		01	/19/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	E, ZIP CODE		
CHARLES	S ROAD C		ARLES ROAD C , NC 28152			
(X4) ID PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETE DATE		
V 290	Facility B at the same these shifts ranging fr hours. This deficiency violation which is detr and welfare of the clic corrected within 45 dapenalty of \$200.00 pe	e time. Staff would cover rom minutes to several y constitutes a Type B rule rimental to the health, safety, ents. If the violation is not ays, an administrative er day will be imposed for so out of compliance beyond	V 290			

Division of Health Service Regulation

STATE FORM STATE FORM If continuation sheet 10 of 10