| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |   | (X2) MULTIPLE CONSTRUCTION  |                     |  | (X3) DATE SURVEY<br>COMPLETED |                  |
|--|---|---|---------------------|--|-------------------------------|------------------|
|  |   | A. BUILDING:  |                     |  | LLILD                         |                  |
|  |   |   | B MING              |  |                               | С                |
|  |   | MHL011-184  | B. WING             |  | 01                            | /18/2023         |
| NAME OF P  | ROVIDER OR SUPPLIER   | STREET A  | DDRESS, CITY, STATE | E, ZIP CODE  |                               |                  |
| ONENO  |   | 650 BAR   | RETT LANE           |  |                               |                  |
| GIVENS   |   | ASHEVII   | LLE, NC 28805       |  |                               |                  |
| (X4) ID  | SUMMARY ST  | ATEMENT OF DEFICIENCIES   | ID                  | PROVIDER'S PLAN OF                                     | F CORRECTION                  | (X5)             |
| PRÉFIX<br>TAG  | ,   | Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)            | PREFIX<br>TAG       | (EACH CORRECTIVE AC<br>CROSS-REFERENCED TO<br>DEFICIEN | THE APPROPRIATE               | COMPLETE<br>DATE |
| V 000  | V 000 INITIAL COMMENTS  A complaint survey was completed on 1/18/23. The complaints were substantiated (intake #NC00195203 and #NC00195633). A deficiency was cited.  This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disability. |   | V 000               |  |                               |                  |
|  |   |   |                     |  |                               |                  |
|  |   |   |                     |  |                               |                  |
|  |   | d for 6 and currently has a very sample consisted of ents.            |                     |  |                               |                  |
| V 540  | 27F .0103 Client Right<br>Grooming  | hts - Health, Hygiene And   | V 540               |  |                               |                  |
|  |   | 3 HEALTH, HYGIENE be assured the right to umane care in the provision |                     |  |                               |                  |
|  | Such rights shall inclute to the:   | ygiene and grooming care.<br>ude, but need not be limited             |                     |  |                               |                  |
|  | daily, or more often a  | for a shower or tub bath<br>as needed;<br>to shave at least daily;    |                     |  |                               |                  |
|  | (3) opportunity barber or a beauticial  | to obtain the services of a<br>n; and                                 |                     |  |                               |                  |
|  | paper and soap for e  |   |                     |  |                               |                  |
|  | individual personal hygiene articles for each indigent client. Such other articles include but are  |   |                     |  |                               |                  |
|  | not limited to toothpa<br>napkins, tampons, sh  | ste, toothbrush, sanitary<br>naving cream and shaving                 |                     |  |                               |                  |
|  | utensil. (b) Bathtubs or show individual privacy sha  | vers and toilets which ensure   |                     |  |                               |                  |
|  | (c) Adequate toilets,   | lavatory and bath facilities<br>a client with a mobility              |                     |  |                               |                  |

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

TITLE (X6) DATE

| STATEMENT OF DEFICIENCIES  |   | (X1) PROVIDER/SUPPLIER/CLIA                                | (X2) MULTIPLE                  | CONSTRUCTION  |                                   | (X3) DATE SURVEY<br>COMPLETED |  |
|--|---|--|--------------------------------|---|-----------------------------------|-------------------------------|--|
| AND PLAN OF CORRECTION   |   | IDENTIFICATION NUMBER:                                     | A. BUILDING: _                 |   | COMP                              | LETED                         |  |
|  |   |  | B. WING                        | B. WING   |                                   | С                             |  |
|  |   | MHL011-184   |                                |   | 01/                               | /18/2023                      |  |
| NAME OF P  | ROVIDER OR SUPPLIER                               |  | DDRESS, CITY, STA<br>RETT LANE | ILE, ZIP CODE   |                                   |                               |  |
| GIVENS   |   |  | LE, NC 28805                   |   |                                   |                               |  |
| (X4) ID  | SUMMARY ST  | ATEMENT OF DEFICIENCIES                                    | ID                             | PROVIDER'S PLAN OF  | CORRECTION                        | (X5)                          |  |
| PREFIX<br>TAG  | (EACH DEFICIENC                                   | Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION) | PREFIX<br>TAG                  | (EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO T<br>DEFICIENCE | TION SHOULD BE<br>THE APPROPRIATE | COMPLETE<br>DATE              |  |
| V 540  | Continued From page                               | e 1  | V 540                          |   |                                   |                               |  |
|  | impairment shall be a                             | vailable   |                                |   |                                   |                               |  |
|  | impairment enail be a                             | ivaliable.   |                                |   |                                   |                               |  |
|  |   |  |                                |   |                                   |                               |  |
|  |   |  |                                |   |                                   |                               |  |
|  | This Rule is not met                              | as evidenced by: and record review the facility            |                                |   |                                   |                               |  |
|  |   | ty and humane care in the                                  |                                |   |                                   |                               |  |
|  | provision of personal                             | -  |                                |   |                                   |                               |  |
|  |   | ng 2 of 2 audited clients                                  |                                |   |                                   |                               |  |
|  | Client #1 and Client                              | #2). The findings are:                                     |                                |   |                                   |                               |  |
|  | Review on 1/3/23 of Client #1's record revealed:  |  |                                |   |                                   |                               |  |
| -Date of admission: 3/1/09;<br>-Diagnoses: Moderate Intellectual and |   |  |                                |   |                                   |                               |  |
|  |   |  |                                |   |                                   |                               |  |
|  | Developmental Disability (IDD), Chronic           |  |                                |   |                                   |                               |  |
|  |   | ve Developmental Disorder<br>I d/o, Central Auditory       |                                |   |                                   |                               |  |
|  | Processing d/o, Ence                              |  |                                |   |                                   |                               |  |
|  | Hypertension.                                     | ,  |                                |   |                                   |                               |  |
|  | D 4/0/00 f /                                      | 01: #01  |                                |   |                                   |                               |  |
|  | -Date of admission: {                             | Client #2's record revealed:                               |                                |   |                                   |                               |  |
|  | -Diagnoses: Mild IDE                              |  |                                |   |                                   |                               |  |
|  | Hyperactivity d/o, combined type, Bipolar d/o, in |  |                                |   |                                   |                               |  |
|  | full remission, most re                           | ecent episode manic,                                       |                                |   |                                   |                               |  |
|  | Cerebral Palsy, and A                             | Anxiety d/o, unspecified.                                  |                                |   |                                   |                               |  |
|  | <br>  Review on 1/6/23 of 2                       | 2 photographs provided by                                  |                                |   |                                   |                               |  |
|  | Client #2's guardian r                            |  |                                |   |                                   |                               |  |
|  |   | e folds of Client #2's lower                               |                                |   |                                   |                               |  |
|  | abdomen;  | (0): 1/10 1 : (  |                                |   |                                   |                               |  |
|  |   | s of Client #2 during one of tober or November 2022.       |                                |   |                                   |                               |  |
|  | Hel Hollie visits III OC                          | IODEI OI NOVEIIIDEI ZUZZ.                                  |                                |   |                                   |                               |  |
|  | Interview on 1/3/23 with Client #1's guardian     |  |                                |   |                                   |                               |  |
|  | revealed:   |  |                                |   |                                   |                               |  |
|  | -tried to visit Client #1                         | •  |                                |   |                                   |                               |  |
|  | -two long time female                             | e staff quit during the nose staff quit, hygiene           |                                |   |                                   |                               |  |
|  | issues started;"                                  | 1030 Stail quit, Hygielle                                  |                                |   |                                   |                               |  |

Division of Health Service Regulation

STATE FORM 6899 QVSK11 If continuation sheet 2 of 6

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | (X2) MULTIPLE CONSTRUCTION |   | (X3) DATE SURVEY<br>COMPLETED |  |
|--|--|---|----------------------------|---|-------------------------------|--|
|  |  |   | A. BUILDING:               |   |                               |  |
|  |  | MHL011-184  | B. WING                    |   | C<br>01/18/2023               |  |
| NAME OF P  | ROVIDER OR SUPPLIER  | STREET ADD  | RESS, CITY, STA            | TE, ZIP CODE  |                               |  |
| GIVENS   |  | 650 BARR  |                            |   |                               |  |
|  |  | ASHEVILL  | E, NC 28805                |   |                               |  |
| (X4) ID<br>PREFIX<br>TAG                         | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   |   | ID<br>PREFIX<br>TAG        | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY) | BE COMPLETE                   |  |
| V 540  | Continued From page  | 2   | V 540                      |   |                               |  |
| V 540  | -Client #1 was unable her nails, or bathe wit-when she visited Clie things hadn't been do and she didn't smell redidn't know bathing severy day; -Client #1 had bowel and sometimes had severy day; -Client #1 needed a bif that happened; -she informed a staff Program of her conceregular hygiene and senad regular contact of the professional (QP) "buthe former Regional manager were the onfacility after the femaleti" isn't all their fault, hire staffhave othe group homes;" -female staff from oth facility now to cover sedidn't think Client #1' the poor hygiene.  Interview on 1/4/23 were vealed: -Client #2 was "not case were were male staff the end of August untithe staff "had no help that were male staff "had no help that were staff that no help that were staff that no help that were staff that the were staff "had no help that were staff that no help that were staff that the were staff that no help that were staff that the were staff that no help that were staff that the were staff th | e to brush her own teeth, trim thout staff assistance; ent #1 "it was clear those oneher hair wasn't clean nice;" schedule but assumed it was issues due to a past surgery stool leakage; oath daily but she didn't know  person at the [local] Day erns about Client #1's lack of staffing concerns; with the former Qualified at they quit;" Director and another male ly staff who worked at the e staff quit; they haven't been able to or staff covering from other  er facilities worked at the shifts; s health suffered because of  ith Client #2's guardian  apable of washing herself that were scalyher shelf ued to the inside of her thigh  f working at the facility from | V 540                      |   |                               |  |
|  | -"brought Client #2 home on three occasionscovered in feces;" -at Christmas when Client #2 came home "her  |   |                            |   |                               |  |

Division of Health Service Regulation

STATE FORM 6899 QVSK11 If continuation sheet 3 of 6

| STATEMENT OF DEFICIENCIES |   | (X1) PROVIDER/SUPPLIER/CLIA                          |                   |  | (X3) DATE SURVEY |                  |
|---------------------------|---|--|-------------------|--|------------------|------------------|
| AND PLAN OF CORRECTION    |   | IDENTIFICATION NUMBER:                               | A. BUILDING:      |  | COMPLETED        |                  |
|                           |   |  |                   |  |                  | С                |
| MHL011-184                |   | B. WING  |                   | 01/18/2023   |                  |                  |
| NAME OF P                 | ROVIDER OR SUPPLIER   | STREET A   | DDRESS, CITY, STA | TE. ZIP CODE   | •                |                  |
|                           |   |  | RETT LANE         | ,  |                  |                  |
| GIVENS                    |   |  | LE, NC 28805      |  |                  |                  |
| (X4) ID                   | SUMMARY ST  | ATEMENT OF DEFICIENCIES                              | ID                | PROVIDER'S PLAN OF CORE  | RECTION          | (X5)             |
| PREFIX<br>TAG             | (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  |  | PREFIX<br>TAG     | (EACH CORRECTIVE ACTION S<br>CROSS-REFERENCED TO THE AF<br>DEFICIENCY) | HOULD BE         | COMPLETE<br>DATE |
| V 540                     | Continued From page   | e 3  | V 540             |  |                  |                  |
|                           | abolf waan't good in  | oor grain area could say                             |                   |  |                  |                  |
|                           |   | ear groin area could say<br>cleaning itgood shape    |                   |  |                  |                  |
|                           | no, better shape, yes   |  |                   |  |                  |                  |
|                           | Tio, belief shape, yes  | idii is better.                                      |                   |  |                  |                  |
|                           | Interview on 12/29/22   | with Community Advocate                              |                   |  |                  |                  |
|                           | #1 for Client #2 revea  | Ţ.   |                   |  |                  |                  |
|                           | -concerned about lac  | k of staff at the facility and                       |                   |  |                  |                  |
|                           |   | le staff to assist with bathing                      |                   |  |                  |                  |
|                           | for Client #2; -staffing concerns began approximately August 2022 when female staff resigned; -facility had rotating female staff to assist with bathing every 2 weeks; |  |                   |  |                  |                  |
|                           |   |  |                   |  |                  |                  |
|                           |   |  |                   |  |                  |                  |
|                           |   |  |                   |  |                  |                  |
|                           | , ,   | s,<br>noticed "skin breakdown                        |                   |  |                  |                  |
|                           |   |  |                   |  |                  |                  |
|                           | turning red" when Client #2 was on a home visit at Thanksgiving.  |  |                   |  |                  |                  |
|                           | at maintagring.   |  |                   |  |                  |                  |
|                           | Attempted to contact  | Community Advocate #2 for                            |                   |  |                  |                  |
|                           |   | but Community Advocate                               |                   |  |                  |                  |
|                           | #2 did not return surveyor's phone call.  |  |                   |  |                  |                  |
|                           | Interview on 1/4/23 with the Day Program Staff  |  |                   |  |                  |                  |
|                           | revealed:   | , 3  |                   |  |                  |                  |
|                           | -Client #1 arrived at the program a couple of   |  |                   |  |                  |                  |
|                           | times and her incontinence briefs were soiled;  |  |                   |  |                  |                  |
|                           | -addressed the soiling with the former Regional   |  |                   |  |                  |                  |
|                           |   | y would take care of it;                             |                   |  |                  |                  |
|                           |   | o arrive at the program with                         |                   |  |                  |                  |
|                           | soiled briefs; "it was r  | •  |                   |  |                  |                  |
|                           |   | staff person to accompany<br>o make sure she cleaned |                   |  |                  |                  |
|                           | herself:  | o make sure she deaned                               |                   |  |                  |                  |
|                           | -knew there were staffing issues at the facility; -Client #1's guardian told him that when she  |  |                   |  |                  |                  |
|                           |   |  |                   |  |                  |                  |
|                           | _   | e facility, her hair was                             |                   |  |                  |                  |
|                           | matted;   | •  |                   |  |                  |                  |
|                           | -thought "there had b   | een some improvement"                                |                   |  |                  |                  |
|                           | with Client #1's hygie  | ne;  |                   |  |                  |                  |
|                           |   | espond after it was brought                          |                   |  |                  |                  |
|                           | to their attentionthey needed a nudge."   |  |                   |  |                  |                  |

Division of Health Service Regulation

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| DIVISION  | of Health Service Regu                           | lation                          |                            |   |                  |
|---|--|---------------------------------|----------------------------|---|------------------|
| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA |  |                                 | (X2) MULTIPLE CONSTRUCTION |   | (X3) DATE SURVEY |
| AND PLAN OF CORRECTION IDENTIFICATION NUMBER:         |  | A. BUILDING:                    |                            | COMPLETED                                   |                  |
|   |  |                                 |                            |   |                  |
|   |  |                                 |                            |   | C                |
|   |  | MHL011-184                      | B. WING                    |   | 01/18/2023       |
|   |  |                                 |                            |   | -                |
| NAME OF P   | ROVIDER OR SUPPLIER                              | STREET A                        | DDRESS, CITY, STA          | TE, ZIP CODE                                |                  |
|   |  | 650 BAR                         | RETT LANE                  |   |                  |
| GIVENS  |  |                                 | LE, NC 28805               |   |                  |
|   |  | ASHEVII                         | LL, NC 20003               |   |                  |
| (X4) ID   |  | ATEMENT OF DEFICIENCIES         | ID                         | PROVIDER'S PLAN OF CORRECTION               | (7.0)            |
| PREFIX  | ,  | Y MUST BE PRECEDED BY FULL      | PREFIX                     | (EACH CORRECTIVE ACTION SHOULD              |                  |
| TAG   | REGULATORY OR I                                  | LSC IDENTIFYING INFORMATION)    | TAG                        | CROSS-REFERENCED TO THE APPROPF DEFICIENCY) | RIATE            |
|   |  |                                 |                            | DEI IOIENOT)                                |                  |
| V 540   | Continued From page                              | . 4                             | V 540                      |   |                  |
| V 340   | Continued From page                              | <del>2</del> 4                  | V 340                      |   |                  |
|   |  |                                 |                            |   |                  |
|   | Interview on 1/6/23 w                            | ith the former Regional         |                            |   |                  |
|   |  | itti tile lottilet Neglotiai    |                            |   |                  |
|   | Director revealed:                               |                                 |                            |   |                  |
|   | -oversaw the operation                           | ons of the facility and four    |                            |   |                  |
|   | other group homes;                               |                                 |                            |   |                  |
|   | -worked at the facility                          | after two long time female      |                            |   |                  |
|   | staff resigned in the s                          | •                               |                            |   |                  |
|   | _  | rdians for Client #1 and        |                            |   |                  |
|   | , ,  | n the two female staff          |                            |   |                  |
|   |  |                                 |                            |   |                  |
|   |  | s" no longer worked at the      |                            |   |                  |
|   | facility;  |                                 |                            |   |                  |
|   | -worked at the facility                          | providing direct care until     |                            |   |                  |
|   | his last day (with Licensee) on December 1 or 2, |                                 |                            |   |                  |
|   | 2022;  | ,                               |                            |   |                  |
|   | · ·  | expressed concern that          |                            |   |                  |
|   | _  |                                 |                            |   |                  |
|   |  | ng bathed"she was in her        |                            |   |                  |
|   |  | as possible she was soiled      |                            |   |                  |
|   | but wouldn't have bee                            | en left in that condition;"     |                            |   |                  |
|   | -the concern was "go                             | ing way backin the              |                            |   |                  |
|   | summer;"   |                                 |                            |   |                  |
|   | -"there was accusation                           | on that she (Client #2) had     |                            |   |                  |
|   |  | days but that wasn't true;"     |                            |   |                  |
|   |  | breakdown" on Client #2;        |                            |   |                  |
|   |  |                                 |                            |   |                  |
|   |  | ng GI (gastrointestinal)        |                            |   |                  |
|   | , ,  | tract infections)was            |                            |   |                  |
|   | soiling herself 2-3 tim                          | es per day;"                    |                            |   |                  |
|   | -when Client #1 left th                          | ne facility to go to the day    |                            |   |                  |
|   |  | ed her and she was clean;       |                            |   |                  |
|   | ,  | rself on the way to the day     |                            |   |                  |
|   | programmaybe had                                 |                                 |                            |   |                  |
|   | programmaybe nac                                 | a loakago.                      |                            |   |                  |
|   |  |                                 |                            |   |                  |
|   |  | with the QP revealed:           |                            |   |                  |
|   |  | the facility since October      |                            |   |                  |
|   | 2022;  |                                 |                            |   |                  |
|   |  | which included overnights at    |                            |   |                  |
|   | the facility;                                    | ·g                              |                            |   |                  |
|   | •  | anent staff at the facility but |                            |   |                  |
|   |  | nent staff at the facility but  |                            |   |                  |
|   | staff from other faciliti                        | ·                               |                            |   |                  |
|   | -Client #2 needed "a lot of prompting" and       |                                 |                            |   |                  |

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sometimes refused to take a shower;

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PRINTED: 01/27/2023 FORM APPROVED

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<br>COMPLETED |  |  |
|---|--|--|--|--|-------------------------------|--|--|
|   |  | MHL011-184   | B. WING                                  |  | C<br>01/18/2023               |  |  |
| NAME OF P   | ROVIDER OR SUPPLIER  |  | DRESS, CITY, STA                         | TE, ZIP CODE   | 1 01/10/2020                  |  |  |
| GIVENS  |  | 650 BARR   |  |  |                               |  |  |
|   | ASHEVILLE, NC 28805  |  |  |  |                               |  |  |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG                      | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | BE COMPLETE                   |  |  |
| V 540   | Continued From page  | ÷ 5  | V 540                                    |  |                               |  |  |
| V 540   | -Client #1 requires "a use the bathrooms toilet and didn't use it -did not observe poor Client #2.  Interview on 12/30/22 Officer (COO) revealed there was a lot of state staff from other location shifts; -the staff who worked time the allegations we employed with the Lice | lot of verbal reminders to ometimes she would get off and then go in her diaper;" hygiene with Client #1 or with the Chief Operating ed: If turnover at the facility and ons (group homes) covered at the facility during the vere made were no longer | V 540                                    |  |                               |  |  |
|   |  |  |  |  |                               |  |  |

Division of Health Service Regulation

STATE FORM 6899 QVSK11 If continuation sheet 6 of 6