					E SURVEY PLETED
A. BUIL		A. BUILDING: _			
	MHL023-154	B. WING			R 20/2023
ROVIDER OR SUPPLIER					
S ROAD B			B		
(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
INITIAL COMMENT	ſS	{V 000}			
This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities. This facility is licensed for 2 and currently has a census of 2. The survey sample consisted of audits of 2 current clients.					
sister facilities. The	e sister facilities will be				
27G .5602 Supervis	sed Living - Staff	{V 290}			
 (a) Staff-client ratio numbers specified if of this Rule shall be enable staff to responeeds. (b) A minimum of corpresent at all times premises, except with a specified plan door capable of remaining without supervision as needed but not lead the client continues the home or common specified periods of (c) Staff shall be priof ollowing client-staff child or adolescent 	as above the minimum in Paragraphs (b), (c) and (d) a determined by the facility to ond to individualized client one staff member shall be when any adult client is on the hen the client's treatment or cuments that the client is ag in the home or community . The plan shall be reviewed ess than annually to ensure to be capable of remaining in unity without supervision for time. resent in a facility in the f ratios when more than one client is present:				
	TOF DEFICIENCIES DF CORRECTION ROVIDER OR SUPPLIER S ROAD B SUMMARY STA (EACH DEFICIENCY REGULATORY OR LE INITIAL COMMENT A follow up survey w deficiency was cited This facility is licens category: 10A NCA Living for Adults wit This facility is licens census of 2. The s audits of 2 current of The facility is locate sister facilities. The identified as sister f 27G .5602 Supervis 10A NCAC 27G .56 (a) Staff-client ratio numbers specified io of this Rule shall be enable staff to resp needs. (b) A minimum of of present at all times premises, except w habilitation plan doo capable of remainir without supervision as needed but not I the client continues the home or commis specified periods of (c) Staff shall be pr following client-staff child or adolescent	OF CORRECTION IDENTIFICATION NUMBER: MHL023-154 ROVIDER OR SUPPLIER STREET AI S ROAD B STREET AI SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) INITIAL COMMENTS A follow up survey was completed on 4/20/23. A deficiency was cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities. This facility is licensed for 2 and currently has a census of 2. The survey sample consisted of audits of 2 current clients. The facility is located in the same building as two sister facilities. The sister facilities will be identified as sister facility A and sister facility C. 27G .5602 Supervised Living - Staff 10A NCAC 27G .5602 STAFF (a) Staff-client ratios above the minimum numbers specified in Paragraphs (b), (c) and (d) of this Rule shall be determined by the facility to enable staff to respond to individualized client needs. (b) A minimum of one staff member shall be present at all times when any adult client is on the premises, except when the client's treatment or habilitation plan documents that the client is capable of remaining in the home or community without supervision. The plan shall be reviewed as needed but not less than annually to ensure the client continues to be capable of remaining in the home or community without supervision for specified periods of time. (c) Staff shall be present in a facility in the fol	TOF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE A. BUILDING: MHL023-154 B. WING ROVIDER OR SUPPLIER STREET ADDRESS, CITY, ST SROAD B STREET ADDRESS, CITY, ST SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID INITIAL COMMENTS {V 000} A follow up survey was completed on 4/20/23. A deficiency was cited. {V 000} This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities. {V 200} The facility is located in the same building as two sister facilities. The sister facilities will be identified as sister facility A and sister facility C. {V 290} 10A NCAC 27G .5602 STAFF (a) Staff-client ratios above the minimum numbers specified in Paragraphs (b), (c) and (d) of this Rule shall be determined by the facility to enable staff to respond to individualized client needs. {V 290} (b) A minimum of one staff member shall be present at all times when any adult client is on the premises, except when the client's treatment or habilitation plan documents that the client is capable of remaining in the home or community without supervision. The plan shall be reviewed as needed but not less than annually to ensure the client continues to be capable of remaining in the home or community without supervision for specified	TOP DEFICIENCIES (X1) PROVIDER/SUPPLIENCIAL (X2) MULTIPLE CONSTRUCTION SPECORRECTION MHL023-154 B. WING	TOP DEFICIENCIES [X1] PROVIDERSUPPLIERICULA [X2] MULTIPLE CONSTRUCTION [X3] DATE SPCORRECTION MHL023-154 B. WING B. WING [04] ROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 324-1 CHARLES ROAD B 324-1 CHARLES ROAD B SIMMARY STATEMENT OF DEFICIENCIES JD PROVIDER'S PLAN OF CORRECTION GEACH COMRECTIVE ACTION SHOULD BE INTIAL COMMENTS [V000] PROVIDER'S PLAN OF CORRECTION GEACH COMRECTIVE ACTION SHOULD BE A follow up survey was completed on 4/20/23. A [V000] CROSS-REFERENCES DEFICIENCY A follow up survey was completed on 4/20/23. A [V 000] [V 000] Fractility is licensed for the following service category: 10A NCAC 27G. 5600C Supervised JD Living for Adults with Developmental Disabilities. This facility is located in the same building as two sister facility A and sister facility C. [V 290] JDACAC 27G. 5602 STAFF (a) Staff-client ratios above the minimum numbers specified in Paragraphs (b), (c) and (d) of this Rule shall be determined by the facility to enable staff to respond to individualized client needs. [V 290] JDACAC 27G. 5602 STAFF (b) A minimum of one staff member shall be present at all times when any adult client is no the premises, except when the client or community without supervision. The plan shall be reviewed as needed b

50NF12

AND PLAN OF CORRECTION		Qulation (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL023-154		CONSTRUCTION	СОМ	E SURVEY PLETED R 20/2023
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
CHARLE	S ROAD B		ARLES ROAD NC 28152	В		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
{\ 290}	present during slee emergency back-up the governing body (2) children o developmental disa one staff present fo present and two sta more clients presen need be present du specified by the em determined by the g (d) In facilities whic diagnosis is substa (1) at least or duty shall be trained withdrawal symptor secondary complica drug addiction; and (2) the service	powever, only one staff need be ping hours if specified by the procedures determined by corrector adolescents with bilities shall be served with r every one to three clients off present for every four or not. However, only one staff ring sleeping hours if ergency back-up procedures governing body. The serve clients whose primary nee abuse dependency: the staff member who is on d in alcohol and other drug ns and symptoms of ations to alcohol and other the so of a certified substance all be available on an	{V 290}			
	facility failed to main present at all times	views and interviews, the ntain one staff member when an adult client was on ing 2 of 2 clients (Clients #1,				
	-Date of Admission -Diagnoses-Mild Int Disability (IDD), Imp Disorder.	/18/23 for Client #1 revealed: -10/5/18 ellectual Developmental oulse Control Conduct				

50NF12

	of Health Service Re NT OF DEFICIENCIES	egulation (X1) PROVIDER/SUPPLIER/CLIA		CONSTRUCTION		E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:			PLETED
						R
		MHL023-154	B. WING			20/2023
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
CHARLE	S ROAD B	829-1 CH	IARLES ROAD	B		
		SHELBY	, NC 28152			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
{V 290}	Continued From pa	ge 2	{V 290}			
	an assessment dat unsupervised time.	ed 1/19/23 for 2 hours of				
	-Date of Admission -Diagnoses- Mild IE Disorder, Oppositio -Updated treatment	DD, Bipolar Disorder, Anxiety nal Defiant Disorder (ODD). t plan effective 3/10/23 ment dated 1/19/23 for 2				
	-Staff cook breakfa leaves us by oursel time." -"Staff don't hang o	3 with Client #1 revealed: st and dinner and "sometimes ves about 30 minutes at a ut in our apartment." f, "I could find staff in A (sister er facility C)."				
	-"Staff usually staye (sister facility C)." -"Staff cook in A (si plate of food. Staff meds (medications phone calls then go	3 with Client #2 revealed: ed in the guys' apartment ster facility A) and bring us a come back at 7pm to pass). Staff come back at 8pm for o back (to sister facility C). nce overnight cause I can				
	-Worked 7 days on then 4 days in the f -Sister facility A had	3 with Staff #1 revealed: 2nd shift in sister facility A and acility and sister facility C. I full time staff. He was filling ity and sister facility C.	E			
	-She worked at a th within this building) this facility and siste	3 with Staff #2 revealed: hird sister facility (not located overnight but was filling in at er facility C on 2nd shift. acility) don't like to be bothered	I			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL023-154	B. WING			R 20/2023
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
CHARLE	S ROAD B		ARLES ROAD	B		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF	CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	COMPLET DATE
{V 290}	Continued From pa	ge 3	{V 290}			
	so I usually stayed i	in C (sister facility C)."				
	Interview on 4/18/23 Professional (QP) r	evealed:				
	apartments (the fac	ed to go through both illity and sister facility C) at t more like every 30 minutes.				
	revealed: -"We had a Q (QP) assessments (for u They had to recreat	3 with the Regional Director who just didn't do the nsupervised time) for a while.' te the process of assessing. 7off on 2nd and 3rd shifts.				
	"We just don't have person) in each fac have that." -The LME/MCO (Lo	the staff to have 1 (staff ility. We never have had to ocal Managing Entity/Manageo				
	treatment plans. -"We don't write a s	care coordinators wrote the eparate provider plan; we only als and attach to the plan. We				
	are at the mercy of update a plan." -There had been a	the care coordinators to lot of turnover with care				
	updated timely. -"There was only 1	ad difficulty getting plans time there was just 1 staff				
	Quality Integrity] sta the scheduled staff	lities) but [the Director of ayed (at sister facility A while worked in the facility and I I bet she didn't clock in."				
	dated and signed 4 Director revealed:	of the first Plan of Protection /19/23 by the Regional				
	ensure the safety of	ction will the facility take to f the consumers in your care? y of individuals that live in				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ECONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		A. BUILDING:			
	MHL023-154				R 20/2023
NAME OF PROVIDER OR SUPPLIEF		DDRESS, CITY, S			
CHARLES ROAD B		IARLES ROAD (, NC 28152) B		
	FATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	THE APPROPRIATE	COMPLETE DATE
{V 290} Continued From p	age 4	{V 290}			
 following was don 1) A form was de Director on April 1 on second and the each hour spent in 2) Staff that work then instructed to document time sp 3) The Regional (QP) of the proceed 4) The "Q" make sleep check form sleeping or order needed while indiv 5) The "Q" will the works in Apartment procedure and do Describe your plant happens. 1) The Regional "Q" on April 19th wat the form and er on the procedure. 	eveloped by the Regional 8th for staff that worked in B-C e morning staff to initial time in Apartment B and C. Ked in B-C on April 18th were how to use the form in order to ent in each apartment. Director then instructed the "Q" dure. a variation on the thirty minute used when individuals are to streamline the documentation viduals are awake on April 19th. then ensure that each staff that in B and C is trained on the cument that they were trained. Ins to make sure the above Director will follow up with the with the "Q" face to face to look insure that staff are being trained.	1			
Protection dated a Regional Director "What immediate ensure the safety To ensure the safe Apartment B and	action will the facility take to of the consumers in your care? ety of individuals that live in C the following was done:				
awake hours until be updated on a r amount of supervi frame and plans r home.	present in both facilities during supervision assessments can new form to specifically state sion required in a 24 hour time evised for individuals in each				
	nours a staff will check between thirty minutes to ensure that				

	of Health Service Re NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE	E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:				PLETED
		MHL023-154	B. WING			R 20/2023
	PROVIDER OR SUPPLIER		DDRESS, CITY, S			20/2020
	FROVIDER OR SUFFLIER		IARLES ROAL			
CHARLE	ES ROAD B		, NC 28152			
(X4) ID			ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLET DATE
{V 290}	Continued From pa	ige 5	{V 290}			
	individuals are asle	ep and safe, sleep time is				
	from 8 pm until 7 ai					
	Describe your plans	s to make sure the above				
	happens.					
		rector will follow ensure that				
		ng two on staff for both homes.				
		Director will complete new				
		ments and follow up with Care				
	Coordinators regard	aing the plans."				
	Peview on 1/20/23	of the third Plan of Protection				
		/20/23 by the Regional				
	Director revealed:					
		ction will the facility take to				
		f the consumers in your care?				
	To ensure the safet	ty of individuals that live in				
	Apartment B and C	the following was done:				
		resent in both facilities to				
		sion will be provided as stated				
		ervision assessments.				
		sessments will be updated on				
		ifically state amount of				
		d in a 24 hour time frame and rdingly for individuals in each				
	home as soon as p					
		k Monday thru Friday all				
		day program from 8:00 am				
		additional second shift staff wil	1			
		until 3:00 am to provide for				
		rage needed. After 3:00 am, a				
		veen the homes every 30				
		supervision. The individuals				
		ve two hours of unsupervised				
		am until 7:00 am. An				
		also be provided from 7:00 am				
	until 8:00 am for ree					
		ds an additional staff person				
		each twelve-hour shift to as required for each home.				
		males have plans to visit				
icion of L	lealth Service Regulation					

		S (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		MHL023-154	B. WING			R 20/2023
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
CHARLE	S ROAD B		ARLES ROAD NC 28152	В		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
{\7 290}	friends for this follo when at least one r home for the any po be scheduled, excer mentioned above for Describe your plans happens. 1) The Regional E the "Q" is schedulir 2) The Regional E supervision assess Coordinators regard Clients #1 and #2 a health needs includ Anxiety Disorder, Ir and ODD. The fact sister facilities A an assessed and appr unsupervised time. the supervision req evidenced by sharin the facility and sister shifts. Clients #1 a out staff for assista and daily care by go staff supervision was staff shared betwee C. This deficiency B rule violation white safety, and welfare administrative pena	wing weekend. However, esident is present in either eriod of time a second staff will ept for the scheduled or the weekdays. Is to make sure the above Director will follow ensure that og two on staff for both homes. Director will complete new ments and follow up with Care ding the plans." The diagnosed with mental ling Mild IDD, Bipolar Disorder, npulse and Conduct Disorder, ility is in the same building as d C. Clients #1 and #2 were oved for up to 2 hours of The facility did not provide uired by Clients #1 and #2 as ng a staff member between er facility C during 2nd and 3rd nd #2 were expected to seek nce with individualized needs bing to sister facility A where as continuous or going to the en the facility and sister facility constitutes an Imposed Type ch is detrimental to the health,	{V 290}			

50NF12