STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING:		R	
		MHL034-357	B. WING			1/2023
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
SHARPE	AND WILLIAMS #6		NOX ROAD I SALEM, NO	27105		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
V 000	INITIAL COMMEN	TS .	V 000			
	A follow up survey was completed on 9/21/23. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G5600A Supervised Living for Adults with Mental Illness. This facility is					
		currently has a census of 4.				
	The survey sample consisted of audits of 3 current clients.					
V 536	27E .0107 Client R Int.	ghts - Training on Alt to Rest.	V 536			
Division of H	10A NCAC 27E .0107 TRAINING ON ALTERNATIVES TO RESTRICTIVE INTERVENTIONS (a) Facilities shall implement policies and practices that emphasize the use of alternatives to restrictive interventions. (b) Prior to providing services to people with disabilities, staff including service providers, employees, students or volunteers, shall demonstrate competence by successfully completing training in communication skills and other strategies for creating an environment in which the likelihood of imminent danger of abuse or injury to a person with disabilities or others or property damage is prevented. (c) Provider agencies shall establish training based on state competencies, monitor for internal compliance and demonstrate they acted on data gathered. (d) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course.					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Division of Health Service Regulation						
	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN OF CORRECTION IDENTIFICA		IDENTIFICATION NUMBER:	A. BUILDING:		COMPI	FIED
MHL034-357					R	
		B. WING		09/21/2023		
			DDEGG OUTL	TATE TIP CODE		
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
SHARPE	AND WILLIAMS #6		NOX ROAD			
		WINSTON	I SALEM, NO	27105		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	.D BE	(X5) COMPLETE DATE
		,		DEFICIENCY)		
V 536	Continued From pa	ge 1	V 536			
		er training must be completed vider periodically (minimum				
	annually).	vider periodically (minimum				
		raining that the service				
		employ must be approved by				
		DD/SAS pursuant to				
	Paragraph (g) of thi	s Rule. onstrate competence in the				
	following core areas					
		e and understanding of the				
	people being serve					
		ng and interpreting human				
	behavior;	ng the effect of internal and				
	external stressors t	hat may affect people with				
	disabilities; (4) strategies	for building positive				
		ersons with disabilities;				
		ng cultural, environmental and				
	organizational facto disabilities;	rs that may affect people with				
		ng the importance of and				
	assisting in the pers decisions about the	son's involvement in making				
		ssessing individual risk for				
	escalating behavior	·. ,				
		cation strategies for defusing				
		ootentially dangerous behavior;				
	and (9) positive b	ehavioral supports (providing				
		ith disabilities to choose				
	activities which dire	ctly oppose or replace				
	behaviors which are					
	(h) Service provide					
	at least three years	nitial and refresher training for				
		tation shall include:				
	\ <i>\</i>	sipated in the training and the				
	outcomes (pass/fail					

STATE FORM 6899 If continuation sheet 2 of 7 CUXX11

Division of Fleath Service Regulation		1		1		
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COMPLETED		
					F	,
	MUI 024 257		B. WING		1	
		MHL034-357			1 09/2	1/2023
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
		4790 LEN	NOX ROAD			
SHARPE	AND WILLIAMS #6		SALEM, NO	27105		
	OLIMA A DV OTA					
(X4) ID PREFIX		TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
TAG	•	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROI		DATE
1710		,		DEFICIENCY)		
V 536	Continued From pa	ge 2	V 536			
	(B) when and	I where they attended; and				
	(C) instructor					
		ion of MH/DD/SAS may				
	•	documentation at any time.				
		ications and Training				
	Requirements:					
		shall demonstrate competence				
		n testing in a training program				
		g, reducing and eliminating the				
	need for restrictive	interventions.				
	(2) Trainers s	shall demonstrate competence				
	by scoring a passin	g grade on testing in an				
	instructor training p	rogram.				
	(3) The training	ng shall be				
		, include measurable learning				
		able testing (written and by				
		avior) on those objectives and				
		ds to determine passing or				
	failing the course.	ас то астолиште разовинд ст				
		ent of the instructor training the				
		ans to employ shall be				
		vision of MH/DD/SAS pursuant				
	to Subparagraph (i)					
		le instructor training programs				
		e not limited to presentation of:				
		•				
		ding the adult learner;				
	` '	for teaching content of the				
	course;	fan avalvatina treie				
		for evaluating trainee				
	performance; and	. C L				
		ation procedures.				
	` '	shall have coached experience				
		program aimed at preventing,				
		nating the need for restrictive				
		st one time, with positive				
	review by the coach	٦.				
		shall teach a training program				
		g, reducing and eliminating the				
		interventions at least once				

Division of Health Service Regulation

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X3) A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL034-357	B. WING		R 09/21/2023	
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI		STATE, ZIP CODE		
CHADDE	AND WILLIAMS #6		NOX ROAD			
SHARPE	AND WILLIAMS #6	WINSTON	SALEM, NO	27105		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
V 536	instructor training a (j) Service provider documentation of ir training for at least (1) Docur (A) who partic outcomes (pass/fail (B) when and (C) instructor (2) The Divisi request and review (k) Qualifications o (1) Coaches requirements as a t (2) Coaches the course which is (3) Coaches competence by contrain-the-trainer inst	chall complete a refresher t least every two years. It is shall maintain initial and refresher instructor three years. Interest in the training and the Interest in t	V 536			
	This Rule is not met as evidenced by: Based interview, the facility failed to ensure staff completed formal refresher training in alternatives to restrictive interventions for 1 of 2 staff (staff #1). The findings are:					
	Review on 9/20/23	of staff #1's record revealed:				

Division of Health Service Regulation

A hire date of 2/25/21

STATE FORM 6899 CUXX11 If continuation sheet 4 of 7

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY LETED
			7. BOILDING.		R	
	MHL034-357		B. WING			1/2023
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
SHARPE	AND WILLIAMS #6		NOX ROAD SALEM, NO	C 27105		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
V 536	- Staff #1's certif Interventions Plus (to restrictive interventions Plus (10/28/23 as the dat - The facility's Di on the certificate Interview on 9/21/2 Professional (QP) r - Staff #1 had be 3/28/23; although h date of training as - The Director with the NCI + training for the correct date fro had still not receive which listed the ince	icate for North Carolina (NCI +) training in alternatives entions listed the date of the she completed the training rector was listed as the trainer. 3 with the Qualified revealed: 2 the trained in NCI + on the er training certificate listed her 10/28/23 as the person who conducted for staff #1 asted a training certificate with the Director; however, she and it to replace the certificate correct date.	V 536			
V 736	10A NCAC 27G .03 EXTERIOR REQUI (c) Each facility and maintained in a saf manner and shall b odor. This Rule is not me Based on observatifailed to maintain the orderly manner. The	d its grounds shall be e, clean, attractive and orderly e kept free from offensive et as evidenced by: ion and interview, the facility he facility in a safe, clean, and he findings are: 14/23 at 3:48 pm and on	V 736			

6899

Division of Health Service Regulation STATE FORM

CUXX11 If continuation sheet 5 of 7

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA	' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		A. BUILDING:				
MHL034-357		B. WING		R 09/21/2023		
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
CHADDE	AND WILLIAMS #6	4790 LEN	NOX ROAD			
SHARPE	AND WILLIAMS #6	WINSTON	SALEM, NO	27105		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
V 736	Continued From pa	ge 5	V 736			
	porch floor which we side near the railing Garage: The walls and of unfinished/unpainted. The garage floor some areas of disconters (unsure if the due to some type of Exterior: The back deck throughout the deck over its entirety and which created a tript. The paint on the deck was peeling. A torn window stacing out onto the	ceiling had spackling and ed drywall or was stained all over with oloration darker in color than e areas of discoloration were f stain, (i.e., oil) or dirt had multiple loose boards king, with the paint peeling d one damaged floorboard o hazard e stairs leading to the back				
	Qualified Professio The facility empty who was responsible facility Since the last seems and provided the photos of the areas working to make aller When she visit needed repairs and maintenance man/cany issues that needed and seems aging system anything that needededededededededededededededededede	bloyed a maintenance man le for making repairs at the survey completed on 4/13/23, ne maintenance man with of concern and he had been I the repairs led the facility, she noted any I followed up with the bowner of the facility regarding leded to be addressed to notify her via an internal ("Slack") if they observed				

Division of Health Service Regulation

STATE FORM 6899 CUXX11 If continuation sheet 6 of 7

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. Bolebino.		R	
		MHL034-357	B. WING			1/2023
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
SHARPE	AND WILLIAMS #6		NOX ROAD SALEM, NO	27105		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
V 736	Continued From pa	ge 6	V 736			
	was kept clean and	onsible for ensuring the facility to assist clients when needed recited deficiency and must				
	be corrected within					

6899

Division of Health Service Regulation STATE FORM