PRINTED: 07/05/2024 FORM APPROVED

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: COMPLETED B. WING MHL034-309 07/01/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 355 RANSOM ROAD INDEPENDENT LIVING AT RANSOM RD WINSTON SALEM, NC 27106 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5)(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) V 000 INITIAL COMMENTS V 000 An annual and follow up survey was completed on July 1, 2024. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600B Supervised Living for Minors with Developmental Disability. This facility is licensed for 4 and has a current census of 1. The survey sample consisted of an audit of 1 current client. V 108 27G .0202 (F-I) Personnel Requirements V 108 10A NCAC 27G .0202 PERSONNEL REQUIREMENTS (f) Continuing education shall be documented. (g) Employee training programs shall be provided and, at a minimum, shall consist of the following: (1) general organizational orientation; (2) training on client rights and confidentiality as delineated in 10A NCAC 27C, 27D, 27E, 27F and 10A NCAC 26B: (3) training to meet the mh/dd/sa needs of the client as specified in the treatment/habilitation plan; and (4) training in infectious diseases and bloodborne pathogens. (h) Except as permitted under 10a NCAC 27G .5602(b) of this Subchapter, at least one staff RECEIVED member shall be available in the facility at all times when a client is present. That staff member shall be trained in basic first aid AUG 05 2024 including seizure management, currently trained to provide cardiopulmonary resuscitation and **DHSR-MH Licensure Sect** trained in the Heimlich maneuver or other first aid techniques such as those provided by Red Cross, the American Heart Association or their equivalence for relieving airway obstruction. Division of Health Service Regulation

LABORATORY DIRECTOR'S OR PROVIDER SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

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TITLE

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL034-309	B. WING		07	01/2024
INDEPEN (X4) ID		M RD 355 RANS WINSTON	27106  PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG		MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		COMPLETE DATE
	(i) The governing bodi implement policies and reporting, investigating and communicable disclients.  This Rule is not met a Based on record revier failed to ensure staff with mental health/developed abuse (mh/dd/sa) needs served affecting 2 of 3 Staff #2). The findings  Review on 6/27/24 of C-An admission date of -Diagnosis of Autism8/1/23 treatment plan Client #1 "requires closs having (an) ability to want addressed elopement.  Review on 6/28/24 of Servealed: -Hire date of 4/25/264/25/16 signed job desparaprofessionalNo documentation of collient #1.	y shall develop and deprocedures for identifying, and controlling infectious seases of personnel and seases of the client population audited staff (Staff #1 and are:  Client #1's record revealed: 10/5/18.  Included a statement that se supervision due to him ander off" and a goal that  Staff #1's personnel record  Cription as a  Ilient-specific training of	V 108	The agency will en all staff have chent specific training. This is be done immediat and the OP will ensure it is don and documente in the staff record.	ely	1/31/24

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STATEMENT OF DEFICIENCIES (X1) PI

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (			(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NONBER.	A. BUILDING		COMPLETED		
		MHL034-309	B. WING		07	/01/2024	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
INDEPEN	DENT LIVING AT RANSO	M RD 355 RANS	OM ROAD				
			SALEM, NC	27106			
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V 108	Continued From page	2	V 108				
	-No documentation of client-specific training of Client #1.						
	-No documentation of client-specific training of						
	Interview on 7/1/24 with -No documentation was Staff #1 and Staff #2 re training regarding Clien	s provided that showed ceived client-specific					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPI	LE CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
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<b> </b>		MHL034-309	B. WING		07/0	1/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
INDEPEN	DENT LIVING AT RANSO	M RD 355 RANS	SOM ROAD			
			SALEM, NC	27106		
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V 108	Continued From page 3		V 108			20-20-00-00-00-00-00-00-00-00-00-00-00-0
	This deficiency constituend must be corrected	tutes a re-cited deficiency d within 30 days.				
V 736	27G .0303(c) Facility a	and Grounds Maintenance	V 736			
	manner and shall be k odor.  This Rule is not met a Based on observation failed to be maintained manner. The findings at the factorie of the f	EMENTS a grounds shall be clean, attractive and orderly ept free from offensive  as evidenced by: and interview, the facility in a clean and attractive are: lity on 6/27/24 at 3:17 pm  a front of the facility ilding and front walkway through the hedges. ergrown tree branches ack walkway, partially alkway from the door at the be backyard. d a brownish-black ab on the bottom and tub near the bottom. ower surround under the a circular metal piece with		The agency will ensure that the facility is clear and presentable weeds and over shrubs will be trimmed. The action of the showerhead. The action of the following the showerhead. The staff will be great in a clean in a	garcy	1/31/24

FORM APPROVED 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 MHL034-309 B WING 07/01/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 355 RANSOM ROAD INDEPENDENT LIVING AT RANSOM RD WINSTON SALEM, NC 27106 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) V 736 3 Chedule. The drywall Continued From page 4 V 736 vanity, a white cloth-like material and a paper oil be repaired. The cobwebs will be deaned. The Dwner will ensure will ensure that I done and will be myong towel in the sink with a piece of white material at the sink drain, a hole in the dry wall beside a broken toilet tissue holder, and white powder-like substance on the floor between the toilet and toilet tissue holder. -The door at the end of Client #1's hallway, which provided an entry into and exit out of the facility had 2-3 cobwebs attached to the inside and bottom of the door. -The door located beside the laundry room, which provided an entry into and exit out of the facility had 2-3 cobwebs attached to the inside and bottom of the door. Interview on 6/27/24 with Client #1 revealed: -He was mostly non-verbal and responded with the word "good" when asked questions. Interview on 6/27/24 with Staff #1 revealed: -She stated she was not aware of any repairs needed at the facility. -Client #1's tub and toilet "needed to be cleaned." -She did not know what the circular metal piece was attached to Client #1's shower surround under the showerhead pipe. -She did not realize he was missing a showerhead. -The bathroom across from Client #1's bathroom was not used by anyone. -No response to the cobwebs on the door at the end of Client #1's hallway as well as no response to the cobwebs on the door near the laundry room. Interview on 6/28/24 with Staff #2 revealed:

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bathroom.

-He did not know what the circular metal piece was under the showerhead pipe in Client #1's

-The brownish-black substance in Client #1's tub

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		MHL034-309	B. WING		07/0	1/2024
NAME OF F	PROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, S	TATE, ZIP CODE		
INDEPEN	DENT LIVING AT RANSO	M RD 355 RANSO WINSTON	OM ROAD SALEM, NC	27106		
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V 736	was "crud or whatever-Second shift staff wer completing the houseld Interview on 7/1/24 wireshe would have her hindividual take care of tree branches in the branches in the branches in Client #1's -She would follow up to concern in Client #1's -She would have the in addressed with staff.	re responsible for keeping tasks at the facility.  th the Owner revealed: husband or another trimming the overgrown ack of the facility at the o address the items of bathroom. his de housekeeping tasks have the service category license to serve adults and	V 736			

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