Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER-COMPLETED. A. BUILDING: R MHL034-336 B. WING 05/24/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 719 INLAND DRIVE HOME CARE SOLUTIONS AT INLAND DRIVE KERNERSVILLE, NC 27284 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) V 000 INITIAL COMMENTS V 000 An annual, complaint and follow up survey was completed on May 24, 2024. The complaint was RECEIVED substantiated (Intake # NC00217165). Deficiencies were cited. AUG 1 2 2014 This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised **DHSR-MH Licensure Sect** Living for Adults with Developmental Disability. This facility is licensed for 3 and has a current The QP of the Day Program is not census of 2. The survey sample consisted of responsible for transportation arrangements audits of 2 current clients. or pick before 8:30 am or after 2:30 pm V 291 27G .5603 Supervised Living - Operations V 291 We have set up arrangements for 10A NCAC 27G .5603 **OPERATIONS** transportation for any individual that needs (a) Capacity. A facility shall serve no more than pick up from the hospital. six clients when the clients have mental illness or developmental disabilities. Any facility licensed Arrangements for transport may take a on June 15, 2001, and providing services to more couple of hours based on availability of staff than six clients at that time, may continue to and a vehicle. provide services at no more than the facility's licensed capacity. We will not transport an individual if they (b) Service Coordination. Coordination shall be pose a threat to staff, themselves or others. maintained between the facility operator and the qualified professionals who are responsible for In situations where the home may not be treatment/habilitation or case management. able to provide timely transport, we will (c) Participation of the Family or Legally indicate that to the hospital. Uber and other Responsible Person. Each client shall be transportation services have been used in provided the opportunity to maintain an ongoing the past. relationship with her or his family through such We will maintain coordination between means as visits to the facility and visits outside facilities, the facility operator and qualified the facility. Reports shall be submitted at least professional. annually to the parent of a minor resident, or the legally responsible person of an adult resident. This is effective immediately and is ongoing. Reports may be in writing or take the form of a Coordination of transport will be monitored conference and shall focus on the client's by the facility operator and qualified progress toward meeting individual goals. professional. (d) Program Activities. Each client shall have

Division of Health Service Regulation

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

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(X6) DATE

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If continuation sheet 1 of 5

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:** COMPLETED A. BUILDING: _ B. WING MHL034-336 05/24/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 719 INLAND DRIVE HOME CARE SOLUTIONS AT INLAND DRIVE KERNERSVILLE, NC 27284 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) V 291 Continued From page 1 V 291 activity opportunities based on her/his choices. needs and the treatment/habilitation plan. Activities shall be designed to foster community inclusion. Choices may be limited when the court or legal system is involved or when health or safety issues become a primary concern. This Rule is not met as evidenced by: Based on record review, interviews, and observation, the facility failed to coordinate with the local hospital affecting 1 of 2 clients (#1). The findings are: Review on 5/24/24 of client #1's record revealed: -Date of Admission: 9/12/23; -Diagnoses: Intellectual Developmental Disabilities, Moderate; Hyperlipidemia, unspecified; and Paraphilia, unspecified; -Hospitalization dated 5/16/24; -Client #1 was ready to be discharged from the hospital on 5/17/24. He was not picked up by the licensee until 5/20/24. Review on 5/21/24 of a text message sent from the Qualified Professional (QP) of the Day Program to the Executive team revealed: -He sent a text message dated 5/19/24 to the QP. Residential Manager (RM), the Owner/licensee, and Co-Owner. Interview on 5/24/24 with client #1 revealed: -"I went to the hospital on Friday until Monday." Interview on 5/24/24 with client #1's legal

Division of Health Service Regulation

guardian revealed:

-Client #1 ran away from the group home on 5/15/24 and he was located on 5/16/24. "The

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		IDENTIFICATION NUMBER.				
		MHL034-336	B. WING		R 05/24/2024	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE						
HOME CARE SOLUTIONS AT INLAND DRIVE 719 INLAND DRIVE KERNERSVILLE, NC 27284						
(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 SHOUL CROSS-REFERENCED TO THE APPROIDEFICIENCY)	N SHOULD BE COMPL	
V 291	Continued From page 2		V 291			
V 291	group home did not 5/20/24; -I did not understanthe hospital that lon Interview on 5/21/24 Program revealed: -"I received a call from 3:25 pm on 5/19/24He told the nurse unclock, and he did not transportation. He was unaware the He received a call from the second s	pick him (client #1) up until d why [client #1] was left at g." with the QP of the Day om [nurse] at the hospital at " infortunately, he was off the ot provide or arrange yould relay the message; we RM was on vacation; from law enforcement on	V 291			
	being taken to the h					
	-"They (licensee) wo the hospital especial discharge." -"I never received a ready for discharge throughout his hospi -The hospital would	or Inland Drive revealed: build not leave a member at ally when they are ready for call when [client #1] was from the hospital or italization; call the individual whose to them. The licensee will				
	facility revealed: -"The facility was sho nurse to hold him (cl The nurse stated, "th service; -I had [client #1] pick -I would probably be RM being on vacatio -He was notified that	the point of contact with the				

FIPA11

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:** COMPLETED A. BUILDING: B. WING MHL034-336 05/24/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 719 INLAND DRIVE HOME CARE SOLUTIONS AT INLAND DRIVE KERNERSVILLE, NC 27284 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) V 291 Continued From page 3 V 291 two days later; -The hospital contacted me after [client #1] was in the hospital for two days and they (hospital) attempted to contact me sooner. He was unsure of the date:" -"The legal guardian (client #1's) texted me to pick [client #1] up and I had already made arrangements." V 736 27G .0303(c) Facility and Grounds Maintenance V 736 10A NCAC 27G .0303 LOCATION AND **EXTERIOR REQUIREMENTS** (c) Each facility and its grounds shall be maintained in a safe, clean, attractive and orderly manner and shall be kept free from offensive odor. This Rule is not met as evidenced by: Based on observation and interviews, the facility failed to ensure the facility and its grounds shall be maintained in a clean, attractive, and orderly manner affecting clients (#1 and #2). The findings

The items were addressed. The oven was -The shower surround and tub was discolored cleaned, the shower curtain was replaced with black stains; and the mattress and box spring were -A mattress and box spring was in the back yard. removed from the back yard.

Interview on 5/24/24 with staff #1 revealed: -"I don't go in the back yard;"

-He was unaware of the mattress and box spring in the back yard.

Observation on 5/23/24 at approximately 5:10pm

-The oven had burnt food particles in the bottom;

of the facility revealed:

Interview on 5/24/24 with staff #2 revealed: -She notified the QP of the Day Program or the The staff have a weekly chore list that they are responsible for upkeep of simple items around the home. Anything not listed on the chore sheets should be reported to the RM and the RM notified

the facility manager.

FIPA11

Division of Health Service Regulation

Division of Health Service Regulation (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ R B. WING MHL034-336 05/24/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 719 INLAND DRIVE HOME CARE SOLUTIONS AT INLAND DRIVE KERNERSVILLE, NC 27284 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE (X4) ID (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) V 736 V 736 | Continued From page 4 RM about maintenance needs at the facility. The facility manager is responsible for grounds upkeep and other repairs. Interview on 5/24/24 with the Co-Owner revealed: -"I am responsible for maintenance needs at The manager is responsible for monthly Inland;" monitoring of the locations and making needed -He and the RM are responsible to make sure repairs. If any repairs are needed in between, the RM is to be notified. staff appropriately clean the facility; -He had big items at the facility picked up by city Maintenance checks will be completed monthly sanitation. If not then he would haul the items and will be ongoing by the facility manager. away on his truck.