

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL080-086</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>09/09/2024</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>BEARD STREET</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1205 BEARD STREET</b> <b>SALISBURY, NC 28144</b>
---	---

(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 SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 000	<p><b>INITIAL COMMENTS</b></p> <p>An annual, complaint and follow up survey was completed on 9/9/24. The complaints were unsubstantiated (intake #'s NC00220173 and NC00220273). Deficiencies were cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disability.</p> <p>The facility is licensed for 3 and currently has a census of 3. The survey sample consisted of audits of 3 current clients.</p> <p>A sister facility (day program) is identified in this report. The sister facility will be identified as sister facility A.</p>	V 000		
V 114	<p><b>27G .0207 Emergency Plans and Supplies</b></p> <p><b>10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES</b></p> <p>(a) Each facility shall develop a written fire plan and a disaster plan and shall make a copy of these plans available to the county emergency services agencies upon request. The plans shall include evacuation procedures and routes.</p> <p>(b) The plans shall be made available to all staff and evacuation procedures and routes shall be posted in the facility.</p> <p>(c) Fire and disaster drills in a 24-hour facility shall be held at least quarterly and shall be repeated for each shift. Drills shall be conducted under conditions that simulate the facility's response to fire emergencies.</p> <p>(d) Each facility shall have a first aid kit accessible for use.</p>	V 114		

Division of Health Service Regulation  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL080-086</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>09/09/2024</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>BEARD STREET</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1205 BEARD STREET</b> <b>SALISBURY, NC 28144</b>
---	---

(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 SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 114	<p>Continued From page 1</p> <p>This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to ensure fire and disaster drills were done quarterly on each shift. The findings are:</p> <p>Review on 8/28/24 of the completed fire and disaster drills for July 2023 - June 2024 revealed: -No 3rd shift fire drill completed for the quarter of October 2023 - December 2023; -No 1st shift disaster drill completed for the quarter of January 2024 - March 2024; -No 2nd shift disaster drill completed for the quarter of April 2024 - June 2024.</p> <p>Interview on 8/28/24 with client #1 revealed: -He has been a resident at the facility for approximately a year; -He had never participated in a disaster drill at the facility; -The last fire drill he participated in was at least a month prior; -He was not aware what to do in case of a fire or disaster and was unable to remember what he did during the last drills.</p> <p>Interview on 8/28/24 with client #2 revealed: -He participated in fire and disaster drills monthly; -He was aware what to do in case of a fire or disaster.</p> <p>Attempted interview on 8/28/24 with client #3 was not successful because the client was unable to understand and communicate information in regards to fire and disaster drills.</p>	V 114		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL080-086</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>09/09/2024</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>BEARD STREET</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1205 BEARD STREET</b> <b>SALISBURY, NC 28144</b>
---	---

(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 SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 114	Continued From page 2  Interview on 8/28/24 with the facility Administrator revealed: -She was aware that fire and disaster drills were required to be completed quarterly on each shift; -She wasn't aware that fire and disaster drills were not completed as required; -The Direct Support Supervisor was responsible for ensuring fire and disaster drills were completed as required.  This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 114		
V 290	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 following client-staff ratios when more than one child or adolescent client is present: (1) children or adolescents with substance abuse disorders shall be served with a minimum of one staff present for every five or fewer minor clients present. However, only one staff need be	V 290		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL080-086</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>09/09/2024</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>BEARD STREET</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1205 BEARD STREET SALISBURY, NC 28144</b>
---	---

(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 SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 290	<p>Continued From page 3</p> <p>present during sleeping hours if specified by the emergency back-up procedures determined by the governing body; or</p> <p>(2) children or adolescents with developmental disabilities shall be served with one staff present for every one to three clients present and two staff present for every four or more clients present. However, only one staff need be present during sleeping hours if specified by the emergency back-up procedures determined by the governing body.</p> <p>(d) In facilities which serve clients whose primary diagnosis is substance abuse dependency:</p> <p>(1) at least one staff member who is on duty shall be trained in alcohol and other drug withdrawal symptoms and symptoms of secondary complications to alcohol and other drug addiction; and</p> <p>(2) the services of a certified substance abuse counselor shall be available on an as-needed basis for each client.</p> <p> </p> <p>This Rule is not met as evidenced by: Based on interviews, record reviews and observations, the facility failed to ensure staffing to meet the individualized needs of the clients served. The findings are:</p> <p> </p> <p>Review on 8/28/24 of Client #1's record revealed: -An admission date of 8/18/23; -Diagnoses of Mild Intellectual Developmental Disability (IDD), Autism Spectrum Disorder, Attention-Deficit/Hyperactivity Disorder and Impulse Disorder; -A treatment plan dated 1/1/24 included, "Behavioral health support needs: One-on-one</p>	V 290		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL080-086</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>09/09/2024</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>BEARD STREET</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1205 BEARD STREET</b> <b>SALISBURY, NC 28144</b>
---	---

(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 SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 290	<p>Continued From page 4</p> <p>staffing...What a Crisis Looks Like for Me? Banging on the wall, Yelling, Throwing items, Insulting others, Physical aggression, Grabbing items to use as weapons, Verbal threats, threatening staff, Property destruction...Where am I now: [Client #1] needs assistance with controlling outbursts and aggression towards others. He needs assistance with processing his anger, frustration and disappointment. He needs to learn coping techniques and proper ways to channel his emotions;"</p> <p>-A Behavior Intervention Plan dated 6/26/23 included, "displays inappropriate sexual behaviors and engages in elopement...Verbal Aggressive Behaviors."</p> <p>Review on 8/28/24 of Client #2's record revealed: -An admission date of 10/1/99; -Diagnoses of Moderate IDD, Autism Spectrum Disorder, Adjustment Disorder, Intermittent Explosive Disorder and Essential Hypertension.</p> <p>Review on 8/26/24 of Client #3's record revealed: -An admission date of 8/15/98; -Diagnoses of Severe IDD, Autistic Disorder, Bipolar Disorder, Intermittent Explosive Disorder, Anxiety Disorder, Encephalopathy and Cardiomyopathy; -A treatment plan dated 10/1/23 and Notice of Approval of Prior Authorization dated 9/1/23 included 1 on 1 worker required, "24 hours weekly...Loud noises - he will start to bang on the walls, furniture and throw things...Crying babies - he will get upset and will sometimes run, hit or throw...Thunder storms - will run and scream, emotional outburst...Bath time - will not go to the bathroom, will yell, curse and refuse to get his items for his bath;"Notice of Approval of Prior Authorization -A Psychological Evaluation dated 11/3/19 that</p>	V 290		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL080-086</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>09/09/2024</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>BEARD STREET</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1205 BEARD STREET</b> <b>SALISBURY, NC 28144</b>
---	---

(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 SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 290	<p>Continued From page 5</p> <p>included, "Full Scale IQ (Intelligence Quotient) 42...has sudden, explosive outbursts of verbal and physical aggression toward property and people...outbursts usually are triggered by noise, holidays, home visits or not getting what [Client #3] wants."</p> <p>Example #1:</p> <p>Review on 8/27/24 of an Incident Report submitted to the North Carolina Incident Response Improvement System by the Qualified Professional on 7/30/24 included: -Date of incident: 7/29/24; -"On July 29, 2024, law enforcement was contacted to conduct a wellness check. Upon arriving at the group home, the Officer was advised by staff (the Group Home Manager) that [Former Staff (FS) #4's] husband arrived on the property and stood in the middle of the driveway. The husband asked [Client #1] if he was the one who sexually assaulted his wife. [Client #1] did not respond but got up and proceeded inside the house. [The Group Home Manager] and [FS #4] advised the husband that he needed to leave. As he was walking away, he stated "y'all need to do something about him."</p> <p>Interview on 9/4/24 with FS #4 revealed: -On 7/29/24, she was the only staff working at the facility with Clients #1 and #3; -"I was in the kitchen cooking. He (Client #1) came up behind me and said I know how to eat p***y and I know how to grab big t*****s. He came up to my behind and pulled his penis out and put his penis on my behind (buttocks);" -She entered Client #2's bedroom and locked the door and entered the ensuite bathroom and locked the door; -"We (facility staff) started using the bathroom in</p>	V 290		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL080-086</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>09/09/2024</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>BEARD STREET</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1205 BEARD STREET</b> <b>SALISBURY, NC 28144</b>
---	---

(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 SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 290	<p>Continued From page 6</p> <p>[Client #2's] bedroom so we could lock both doors and [Client #2] couldn't come in on us;"</p> <p>-She called her husband while she was in the bathroom and informed him that she was scared and wasn't sure what to do since facility staff had been informed they were not allowed to contact 911 for any reason;</p> <p>-"He (Client #1) tore the lock off Client #2's (bedroom) door;"</p> <p>-She yelled through the bathroom door and asked Client #1 how he unlocked the bedroom door and he informed her, "Oh, I'm sneaky;"</p> <p>-She repeatedly instructed Client #1 to move away from the door and leave the bedroom;</p> <p>-"I end up pushing him (Client #1) and running past him;"</p> <p>-She immediately called and informed the Vice President of Operations of the incident;</p> <p>-She had completed a T-Log but she was so upset that she didn't know what she had written;</p> <p>-She had reported other incidents in the past (dates unknown) but they were ignored..."He (Client #1) takes his shirt off. When you tell him to put it back on, he'll say 'no, you know you like what you see';"</p> <p>-"Most of the time I was there by myself with Clients #1 and #3 while Client #2 was at sister facility A;"</p> <p>-Staff #2 was scheduled to work with her on 7/29/24 however Client #2's transportation worker was absent, so she transported him to and from sister facility A;</p> <p>-Staff #2 was out of the facility for at least an hour each time she left;</p> <p>-She had filed charges against Client #1 for sexual harassment, "I actually have a court date on October 22nd (2024) for sexual harassment."</p> <p>Review on 9/9/24 of a T-Log completed by FS #4 on 7/29/24 revealed:</p>	V 290		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL080-086</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>09/09/2024</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>BEARD STREET</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1205 BEARD STREET</b> <b>SALISBURY, NC 28144</b>
---	---

(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 SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 290	<p>Continued From page 7</p> <p>-1:42pm "He's (Client #1) been a sexually frustrated person today he's been talking very nasty a doing things that has been inappropriate hes been walking aroundnd with his hand in his pants following in behind me all day i couldnt use the bathroom until other staff came bach because I felt unsafe at this point i was in the kitchen cooking he came behind me with his shirt off i told him to stop coming in the kitchel while im cooking i was gettin a pot from up under the cabinet he came with a ball a out it on butt so a his piont i said that u have violeted my space and dont u ever do that again so he got mad and said stop f*****g with me and throw the dish drain."</p> <p>Review on 9/9/24 of a T-Log completed by Staff #2 on 7/29/24 revealed: -6:15pm "[Client #1] has sexually harassed a staff. After repeatedly being told to stop throughout the entire day, he didn't. He has made inappropriate comments towards staff as well. He has attempted to pick up a deep fridge and thought he was gonna throw it. He has harassed, threatened and been very disrespectful towards staff. He has invaded staff personal space as well."</p> <p>Interview on 9/4/24 with Client #1's Care Coordinator revealed: -She arrived at the facility at approximately 3:00pm on 7/29/24; -She observed FS #4 outside the facility..."She was devastated. She was not making this up. It just felt very awful. She's like, there's no other staff and she's cooking. He (Client #1) had sexually gyrated on her backside (buttocks)."</p> <p>Example #2:  Review on 8/28/24 of an internal Incident Report</p>	V 290		



Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL080-086</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>09/09/2024</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>BEARD STREET</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1205 BEARD STREET</b> <b>SALISBURY, NC 28144</b>
---	---

(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 SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 290	<p>Continued From page 8</p> <p>dated 8/18/24 and 8/20/24 revealed:</p> <p>-Portion completed by FS #3 on 8/18/24: "[Client #3] had a behavior today at 6:10pm he hit/slapped [Client #2] on the face two times while I had went to the bathroom;"</p> <p>-Portion completed by nursing: "No Treatment Required. Notified and seen resident (Client #2) on 8/20 (2024), resident denied pain to site, No abrasions, scratches, or redness noted during examination."</p> <p>Interview on 9/3/24 with FS #3 revealed:</p> <p>-She was the only staff working at the facility with Clients #1, #2 and #3..."[Client #3] has just come back home from when his parents took him out to eat. I went to the restroom. I heard screaming and I heard [Client #2] yelling stop. He slapped him multiple times. I told [Client #2] if something like that happens, walk away from him. He'll (Client #2) just stand there and let him (Client #3) do it (assault him);"</p> <p>-She had observed Client #3 on numerous occasions when he picked up items and threw them at people.</p> <p>Example #3:</p> <p>Review on 8/28/24 of an internal Incident Report completed by FS #3 on 8/18/24 revealed:</p> <p>-"10:00am [Client #1] was playing with his [toy] gun this morning and when I was picking out another client's clothes, [Client #1] hit me with the [toy] gun dart from behind. I told him to stop that it was not appropriate behavior and after me asking him to stop he went and did it again and then told me, hit you in your butt (buttocks)."</p> <p>Interview on 9/3/24 with FS #3 revealed:</p> <p>-On 8/18/24, she was the only staff working at the facility with Clients #1, #2 and #3..."One of the</p>	V 290		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL080-086</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>09/09/2024</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>BEARD STREET</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1205 BEARD STREET</b> <b>SALISBURY, NC 28144</b>
---	---

(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 SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 290	<p>Continued From page 9</p> <p>clients there, [Client #1], he was playing with a [toy] gun. He ended up shooting me in the back area. I prompted him and told him that wasn't appropriate behavior. He just started laughing even though I told him to not do it...A couple of times, he'd get up too close and try to rub himself (penis) on you...He tried to throw a ball at me in the breast area. He shouldn't be doing those things... I had decided to just go ahead and do a claim (file charges) for sexual assault;"</p> <p>-She had been informed by the Group Home Manager when she began her employment 3 weeks prior that there were supposed to be 3 staff working 1st and 2nd shifts because Clients #1 and #3 had 1 on 1 staff;</p> <p>-"I was always there by myself with all 3 clients. At that house (facility), we had a lot of staff quitting because of the issues with [Client #1]."</p> <p>Example #4:</p> <p>Review on 9/9/24 of a T-Log completed by Staff #2 on 7/29/24 revealed: -6:11pm "While watching his (Client #3) movie, [Client #1] went into his room and hit him (Client #3) in his eye. [Client #3] yelled stop [Client #1] and [Client #1] acted like nothing happened and said he was acting crazy for no reason and then blamed [Client #2], who wasn't even there."</p> <p>Review on 9/9/24 of a T-Log completed by FS #4 on 7/29/24 revealed: -2:03pm "[Client #3] had a god day but [Client #1] has been doing things to him like messing with his movies going in his room and just causing him to have a behavior."</p> <p>Interview on 8/28/24 with Client #1 revealed: -"Hit a client (Client #3) in the eye;" -He didn't want to answer additional questions</p>	V 290		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL080-086</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>09/09/2024</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>BEARD STREET</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1205 BEARD STREET</b> <b>SALISBURY, NC 28144</b>
---	---

(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 SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 290	<p>Continued From page 10</p> <p>about the incident.</p> <p>Interview 9/4/24 with FS #4 revealed:</p> <ul style="list-style-type: none"> <li>-On 7/29/24, she was the only staff working at the facility with Clients #1 and #2;</li> <li>-She was in the kitchen and heard Client #3 yell from his bedroom;</li> <li>-As she entered Client #3's bedroom, Client #1 was exiting;</li> <li>-She asked Client #1 why he was in Client #3's bedroom, but he didn't answer;</li> <li>-She observed Client #3 crying and holding his eye and when she asked him what happened, he informed her, "[Client #1];"</li> <li>-Client #3 had no visible injuries;</li> <li>-She informed Staff #2 of the incident and requested she enter notes into T-Log at the end of the day;</li> <li>-Client #1, "was a bully and engaged in fighting the other clients;"</li> <li>-The Group Home Manager was informed of the incident and instructed her to document a T-Log;</li> <li>-She had made complaints about Client #1's treatment of the other clients to the Group Home Manager and the Qualified Professional, but nothing had changed.</li> </ul> <p>Attempted interviews on 9/5/24, 9/6/24, 9/9/24 with Staff #2 were not successful as she didn't return telephone calls.</p> <p>Interview on 8/28/24 with the facility Administrator revealed:</p> <ul style="list-style-type: none"> <li>-She had not been made aware that Client #1 physically assaulted Client #3 on 7/29/24 and was unable to locate an incident report.</li> </ul> <p>Example 5:</p> <p>Observation on 8/28/24 of the facility from</p>	V 290		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL080-086</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>09/09/2024</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>BEARD STREET</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1205 BEARD STREET</b> <b>SALISBURY, NC 28144</b>
---	---

(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 SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 290	<p>Continued From page 11</p> <p>approximately 9:35am - 11:45am revealed 2 staff (the Group Home Manager and Staff #1) and Clients #1, #2 and #3.</p> <p>Review on 9/9/24 of the staff schedule for the month of June 2024 revealed: -No schedule available for 1st shift on 6/1/24 and 6/8/24; -No schedule available for 2nd shift on 6/1/24 - 6/2/24, 6/7/24 and 6/8/24; -One staff worked 1st shift on 6/2/24 - 6/7/24, 6/15/24 and 6/29/24; -One staff worked 2nd shift on 6/3/24 - 6/6/24, 6/9/24, 6/15/24, 6/22/24, and 6/29/24 - 6/30/24.</p> <p>Review on 9/9/24 of the staff schedule for the month of July 2024 revealed: -One staff worked 1st shift on 7/7/24, 7/13/24 - 7/14/24, and 7/27/24 - 7/28/24; -One staff worked 2nd shift on 7/7/24 - 7/8/24, 7/13/24 - 7/14/24, 7/16/24, 7/19/24, and 7/26/24 - 7/28/24;</p> <p>Review on 9/9/24 of the staff schedule for the month of August 2024 revealed: -No schedule available for 1st shift on 8/17/24; -No schedule available for 2nd shift on 8/31/24; -One staff worked on 1st shift on 8/1/24 - 8/5/24, 8/9/24 - 8/12/24 and 8/24/24 - 8/25/24; -One staff worked on 2nd shift on 8/1/24 - 8/5/24, 8/9/24 - 8/13/24, 8/18/24 - 8/19/24, 8/21/24 and 8/24/24 - 8/25/24.</p> <p>Interview on 9/4/24 with Client #1's Care Coordinator revealed: -She had visited the facility on 8/27/24 at approximately 3:00pm and there were 2 staff present with 3 clients; -Prior to her departure at approximately 4:00pm, 1 of the 2 staff left the facility property leaving only</p>	V 290		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL080-086</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>09/09/2024</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>BEARD STREET</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1205 BEARD STREET</b> <b>SALISBURY, NC 28144</b>
---	---

(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 SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 290	<p>Continued From page 12</p> <p>1 staff with 3 clients.</p> <p>Interview on 8/28/24 with Staff #1 revealed: -She had worked at the facility for 2 weeks; -She was informed by the Group Home Manager when she was employed that they were required to have 3 staff on 1st shift (7:00am - 3:00pm) when all 3 clients were present; -Today was the 3rd day she had worked 1st shift with 3 clients and 2 staff present in the facility.</p> <p>Interviews on 8/27/24, 8/28/24 and 9/5/24 with the Group Home Manager revealed: -On 8/28/24 during observations from 9:35am - 11:45am, there should have been 3 staff present instead of 2 but a new staff failed to arrive for work; -She was responsible for scheduling staff; -Client #1 was required to have 1 on 1 staff 24 hours a day and Client #3 had 1 on 1 staff during awake hours; -One staff worked 3rd shift; -Client #1, "can be very aggressive...he can be sexually aggressive as well...he hit [FS #3] in the breast;" -FS #3 had informed her that she didn't feel safe working with Client #1, so she was transferred to another facility; -She was unable to find part of the staff schedule, but she was going to ensure what she had was correct and then provide the documentation; -Monday - Friday staff worked 3 shifts (1st 7:00am - 3:00pm, 2nd 3:00pm - 11:00pm and 3rd 11:00pm - 7:00am) and on Saturday and Sunday, staff worked 2 shifts (1st 7:00am - 7:00pm and 2nd 7:00pm - 7:00am).</p> <p>Interview on 8/29/24 with the Qualified Professional revealed: -She was concerned that Client #1 hadn't been</p>	V 290		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL080-086</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>09/09/2024</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>BEARD STREET</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1205 BEARD STREET</b> <b>SALISBURY, NC 28144</b>
---	---

(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 SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 290	<p>Continued From page 13</p> <p>discharged since the facility didn't have the number of staff to provide 1 on 1 for him; -I have concerns about his (Client #1) behavior. I know that there are safety concerns. He is definitely a liability and threat. I know the Supervisors (Group Home Manager) having trouble with [Client #1]. He has hurt staff. He has hurt clients. It's not pretty."</p> <p>Interviews on 8/28/24 and 8/29/24 with the Administrator revealed: -Client #1 was approved for a 1 on 1 staff, "He just recently got the enhanced rate. I believe July. That has started...We've been trying to get that service provided...We've been providing the 1 on 1 service since April (2024) or May (2024) because of the incidents that were happening with him;" -Client #3 was required to have a 1 on 1 staff; -On 7/29/24 and 8/27/24, there were 2 staff clocked in from 3:00pm - 4:00pm so she thought Client #1's Monitoring Specialist must have been mistaken; -On 8/28/24 during observations from 9:35am - 11:45am, there should have been 3 facility staff; -She had not been made aware that a staff had not arrived at work.</p> <p>Interview on 9/9/24 with the Vice President of Operations revealed: -Client #1 was staffed a 1 on 1 worker 7 days a week from 7:00am - 11:00pm, "His plan does not say 24 hours." -Client #3 was staffed a 1 on 1 worker Monday - Friday from 7:00am - 3:00pm; -She was not aware that a 1 on 1 worker wasn't always staffed during those times.</p> <p>Example 6:</p>	V 290		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL080-086</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>09/09/2024</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>BEARD STREET</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1205 BEARD STREET</b> <b>SALISBURY, NC 28144</b>
---	---

(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 SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 290	<p>Continued From page 14</p> <p>Interview and observation on 8/28/24 at 10:31am with Client #3 revealed the client stood in the kitchen and rubbed his fingers over his pants that covered his groin during the interview with Division of Health Service Regulation surveyor.</p> <p>Interview on 8/28/24 with Client #1 revealed: -He was court ordered in June 2024 to be on house arrest until his next court date (date unknown) but he wasn't sure what the charges were..."I'm trying to behave so I can go out;" -"I might have pushed [Client #2] after he dropped my phone (Client #2 suffered a fractured arm). I just pushed him on the ground. That's all I did...Sometimes [Client #2] gets on my nerves...One day I threw my phone and broke the back of my phone."</p> <p>Interview on 9/3/24 with Client #1's guardian revealed: -She had been seeking alternate placement for Client #1..."We believe he needs more 1 on 1. We're not ever going to deny that he can be difficult. He is very intelligent and articulate in many ways. People forget he's really more like an 8-year-old child in a man's body;" -One on one had been difficult for the facility to provide because of a lack of staff even though it was recommended by his Behavioral Therapist; -"I know they (facility staff) tried for a while to do the 1 on 1. Now, it went from having 2 staff in the house (facility) to having 1 (staff) in the house;" -Client #1 had pending legal issues and was on court ordered house arrest until his next court date..."He has charges in [a neighboring state] of indecent liberty with a minor;" -Client #1 also had pending charges from approximately a month prior for sexual misconduct with [FS #4].</p>	V 290		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL080-086</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>09/09/2024</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>BEARD STREET</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1205 BEARD STREET</b> <b>SALISBURY, NC 28144</b>
---	---

(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 SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 290	<p>Continued From page 15</p> <p>Interviews on 9/9/24 with Client #1's Care Coordinator and the Care Coordinator Supervisor revealed: -Facility staff were required to provide 1 on 1 staffing for Client #1 during awake hours; -"He's (Client #1) supposedly making sexual advances towards the female staff;" -"You can see he's a huge community risk. This is a tough case."</p> <p>Interview on 9/4/24 with Client #1's Monitoring Specialist from the local LME/MCO revealed: -"Sometimes I get the impression they (facility) don't do adequate staffing for the clients they take...I have felt them to be kind of secretive;" -Client #1 was required to have 1 on 1 staff; -"Staff verbalize they are scared of him (Client #1). He walks around the group home (facility) because he's on house arrest. He was charged with penetrating a minor child. They're not staffing. They have these very young ladies in there working. That being said, he broke the arm of another resident. He's going in and out of the other 2 guys bedrooms and he's obviously very interested in sex."</p> <p>Interview on 9/5/24 with Client #3's Care Coordinator from the local LME/MCO revealed: -Facility staff were required to provide 1 on 1 staff for Client #3 Monday - Friday from 7:00am - 3:00pm; -Client #3 had a history of eloping while in the community.</p> <p>Review on 9/9/24 of a Plan of Protection completed by the Administrator on 9/9/24 revealed: "What immediate action will the facility take to ensure the safety of the consumers in your care? 1) The Administrator will re-Inservice the Qualified</p>	V 290		



Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL080-086</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>09/09/2024</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>BEARD STREET</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1205 BEARD STREET</b> <b>SALISBURY, NC 28144</b>
---	---

(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 SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 290	<p>Continued From page 16</p> <p>Professional, Direct Support Supervisor and all Direct Support staff to ensure [Client #1] has a dedicated 1:1 staff at all waking hours times as clarified by the LME with updated plan. No other residents can be left with [Client #1] with only one staff.</p> <p>2) The clinical team (Administrator, QP, Nursing staff, Hab (Habilitation) Spec (Specialist), Administrative staff, etc) will do random phone and/or visual checks at least daily with the DSP (Direct Support Paraprofessional) team to ensure appropriate staffing is in place at the home for daily for the next 90-days to ensure appropriate staffing.</p> <p>3) The team will install an alarm on his bedroom door to ensure health and safety</p> <p>4) Will evaluate to discuss appropriate placement for [Client #1].</p> <p>5) Qualified Professional will contact MCO (Managed Care Organization) about updating [Client #1] ISP (Individual Support Plan). Describe your plans to make sure the above happens.</p> <p>1) The Direct Support Supervisor will ensure appropriate staffing for [Client #1] is in place or come in and ensure coverage is appropriate.</p> <p>2) The Qualified Professional developed a back-up emergency plan to address staffing ratios and ensure the residents are protected. Clinical and Management will cover shifts when other DSPs are not available."</p> <p>There were 3 adult males residing in the facility with diagnoses that included Mild/Moderate/Severe IDD, Autism Spectrum Disorder, ADHD, Impulse Disorder, Intermittent Explosive Disorder, Adjustment Disorder, Bipolar Disorder, Anxiety Disorder, Static Encephalopathy, Cardiomyopathy, Speech Impairment, and Essential Hypertension. Clients</p>	V 290		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL080-086</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>09/09/2024</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>BEARD STREET</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1205 BEARD STREET</b> <b>SALISBURY, NC 28144</b>
---	---

(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 SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 290	<p>Continued From page 17</p> <p>#1 and #2 have histories that include elopement, property destruction, verbal, physical and sexual abuse and stealing. Despite the need for a 1 on 1 staff for Client #1 during awake hours documented on his admission assessment, treatment plan and behavior support plan, 1 on 1 was not provided as recommended. The need for a 1 on 1 staff for Client #1 was based on his history of property destruction, and verbal, physical and sexual assault. As a result of Client #3's history of property destruction, verbal and physical assault and elopement, he was required to have 1 on 1 staff Monday - Friday 7:00am - 3:00pm. During the months of June 2024 - August 2024, 59 out of 184 shifts were not staffed as required. During the 59 shifts that the facility was out of compliance for staffing, Client #1 physically assaulted Client #3 and sexually assaulted FS #3 and FS #4 and Client #3 physically assaulted Client #2. This deficiency constitutes a Type A1 rule violation for serious neglect and must be corrected within 23 days.</p>	V 290		