STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL011-446	A. BUILDING: _____ B. WING _____	R-C 08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONARCH DBA UMAR-GIVENS	650 BARRETT LANE ASHEVILLE, NC 28803

(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	INITIAL COMMENTS A complaint and follow up survey was completed on August 7, 2024. The complaints were substantiated (NC#00219559 and NC#00219397). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disability. This facility is licensed for 6 and currently has a census of 5. The survey sample consisted of audits of 4 current clients. A sister facility is identified in this report. The sister facility will be identified as sister facility A. Staff and/or clients will be identified using the letter of the facility and a numerical identifier.	V 000	This section intentionally left blank RECEIVED SEP 11 2024 DHSR-MH Licensure Sect	
V 105	27G .0201 (A) (1-7) Governing Body Policies 10A NCAC 27G .0201 GOVERNING BODY POLICIES (a) The governing body responsible for each facility or service shall develcp and implement written policies for the following: (1) delegation of management authority for the operation of the facility and services; (2) criteria for admission; (3) criteria for discharge; (4) admission assessments, including: (A) who will perform the assessment; and (B) time frames for completing assessment. (5) client record management, including: (A) persons authorized to document; (B) transporting records; (C) safeguard of records against loss, tampering, defacement or use by unauthorized persons; (D) assurance of record accessibility to authorized users at all times; and	V 105	UMAR Division Team Leads and Directors in- serviced 8/13/2024 on Admission policy completed by VP of Operations, UMAR Division. Before any new admissions, Team Leads will complete Admissions Checklists in its entirety and VP of Operations will review to ensure completion. Implementation 8/30/24 Ongoing	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL011-446	A. BUILDING: _____ B. WING _____	R-C 08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONARCH DBA UMAR-GIVENS	650 BARRETT LANE ASHEVILLE, NC 28803

(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 105	Continued From page 1 (E) assurance of confidentiality of records. (6) screenings, which shall include: (A) an assessment of the individual's presenting problem or need; (B) an assessment of whether or not the facility can provide services to address the individual's needs; and (C) the disposition, including referrals and recommendations; (7) quality assurance and quality improvement activities, including: (A) composition and activities of a quality assurance and quality improvement committee; (B) written quality assurance and quality improvement plan; (C) methods for monitoring and evaluating the quality and appropriateness of client care, including delineation of client outcomes and utilization of services; (D) professional or clinical supervision, including a requirement that staff who are not qualified professionals and provide direct client services shall be supervised by a qualified professional in that area of service; (E) strategies for improving client care; (F) review of staff qualifications and a determination made to grant treatment/habilitation privileges: (G) review of all fatalities of active clients who were being served in area-operated or contracted residential programs at the time of death; (H) adoption of standards that assure operational and programmatic performance meeting applicable standards of practice. For this purpose, "applicable standards of practice" means a level of competence established with reference to the prevailing and accepted methods, and the degree of knowledge, skill and care exercised by other practitioners in the field;	V 105	This page intentionally left blank	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL011-446	A. BUILDING: _____ B. WING _____	R-C 08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONARCH DBA UMAR-GIVENS	650 BARRETT LANE ASHEVILLE, NC 28803

(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 105	Continued From page 2 This Rule is not met as evidenced by: Based on record review and interview, the facility failed to implement their written policies on screening and admission assessments for 2 of 4 audited clients (#1 and #4). The findings are: Review on 7/25/24 of the Facility's Policy and Procedure Manual dated 8/22/23: -Section: Admission Assessment and Reassessment. -"Admission decisions for residential vacancies and continued stays will be based on the admission assessment." -"In order to be admitted to Monarch (Licensee) for any service an individual will receive an assessment that meets our standards related to the screening and assessing of individuals according to service definition." -"The assessment provides guidance in determining if the individual has the need for a service(s)/support(s) being requested. In addition, the assessment will provide information to help the agency determine if it can provide for the individual's needs and if the agency has the ability to respond to the individual needs in a manner which is likely to benefit the individual. The information in the assessment should accurately describe the person." -"In residential (24 hour) services Monarch will in accordance with the screening process	V 105	This page intentionally left blank	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL011-446	A. BUILDING: _____ B. WING _____	R-C 08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONARCH DBA UMAR-GIVENS	650 BARRETT LANE ASHEVILLE, NC 28803

(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 105	Continued From page 3 ensure each individual will obtain a physical exam as appropriate. The evaluation will be completed within 24 hours of admission by a physician or mid-level practitioner. The evaluation will include a full review of systems, vital signs and referral to a primary care physician or local emergency medical provider as needed." -"Each individual (both in non-24-hour services and 24-hour services) will be screened related to their need for a physical assessment. Monarch will inquire about the individual's primary care provider and whether they have had a physical in the last 12 months." -"Each individual will be screened related to their need for a nutritional assessment. Monarch will ask questions including recent weight loss/gain, current treatment for a nutritional/dietary concern and if the individual has any current symptoms of nausea, vomiting, diarrhea and/or change in appetite." Review on 7/18/24 and 7/23/24 of Client #1's record revealed: -Admission Date: 7/15/24. -Diagnoses: Anxiety Disorder, Unspecified; Hypothyroidism; Cerebral Palsy; Malignant Neoplasm of pituitary gland; Vitamin D Deficiency; Unspecified Asthma (uncomplicated); Moderate Intellectual Developmental Disability (IDD); Dorsalgia, Unspecified; Hypopituitarism; and Other Seasonal Allergic Rhinitis. -No evidence of a physical assessment, health screening or nutritional assessment completed by the licensee prior to admission. -Admission Assessment dated 7/23/24 (8 days after admission) completed by the Residential Director/Qualified Professional (RD/QP) revealed: -"[Client #1] has lived at home. Seeking placement in residential facility as periodic staffing at home has been unstable. Needs	V 105	This page intentionally left blank	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL011-446	A. BUILDING: _____ B. WING _____	R-C 08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONARCH DBA UMAR-GIVENS	650 BARRETT LANE ASHEVILLE, NC 28803

(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 105	Continued From page 4 exceed what mom can provide." -"[Client #1] needs full assistance with most activities of daily living (ADL). [Client #1] will need assistance getting to know her new community and connecting to activities of personal interest." -"[Client #1] is not ambulatory. She uses a power wheelchair. She needs complete and safe assistance with all transfers. Staff are to assist with personal care and hygiene needs. A Hoyer lift has been ordered and for the group home. Once [Client #1] is lying down she is not able to roll over or sit up. She has had rods in her back since childhood, related to her Cerebral Palsy (CP). [Client #1] uses a toe separator and ankle-foot orthosis (AFOs). At night, she uses a hand splint on her left hand to prevent contractures. [Client #1] uses incontinence briefs but can also tell staff when she needs assistance to transfer to the toilet and use the bathroom. [Client #1] uses a custom shower chair. Staff must fully assist [Client #1] with bathing to ensure hygiene and prevent skin breakdown. [Client #1] can brush her teeth but needs assistance from staff with hard-to-reach places. [Client #1] has had vomiting issues related to her seasonal allergies in the past. She must be monitored at night to ensure she does not aspirate. She must be immediately sat up if she is vomiting." Review on 7/23/24 of Client #4's record revealed: -Admission Date: 7/22/24. -Diagnoses: Dysthymia (Unspecified Depressive Disorder), Mild IDD, HNO5 Thyroid (Thyroid Nodule), and Psychological Factor Hypothyroidism. -No evidence of an updated physical assessment, health screening or nutritional assessment completed by the licensee prior to being admitted to the facility. -Admission Assessment dated 7/23/24 (1 day	V 105	This page intentionally left blank	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL011-446	A. BUILDING: _____ B. WING _____	R-C 08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONARCH DBA UMAR-GIVENS	650 BARRETT LANE ASHEVILLE, NC 28803

(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 105	Continued From page 5 after admission) completed by the RD/QP revealed: -Client #4 was discharged from Sister Facility A. -"[Client #4] needs ongoing assistance with some ADLs. Verbal prompting needed for personal hygiene tasks and keeping her room tidy. [Client #4] needs assistance managing personal health and med (medication) administration. She requires encouragement for regular exercise and healthy food choices." -"Recent gastrointestinal issues. She has one colonoscopy scheduled, but will need to have another, she did not have successful prep (preparation) before one scheduled in June 2024. Needs primary care established in [local city] to obtain referrals. [Client #4] uses a continuous positive airway pressure machine (CPAP). She needs assistance putting the water in, and then can use the machine independently." Interviews on 7/23/24 and 7/26/24 with the RD/QP revealed: -The Team Leader/Qualified Professional (TL/QP) would "typically" be responsible for admitting clients to the facility, but "I have been performing that function...helping with QP duties at that home (facility)." -"...sometimes we'll do screenings virtually...didn't do virtual screening (for Client #1) prior to house (facility) visit...we felt like until we saw her on site we wouldn't have much to access virtually." -"Admission assessments and screenings are done ahead of time...should be completed at the time the client is admitted." -No physical assessment, health screening, or nutritional assessment was completed for Client #1 according to policy prior to admission. -Client #1 was admitted on 7/15/24, Facility Admission Assessment completed by the RD/QP	V 105	This page intentionally left blank	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL011-446	A. BUILDING: _____ B. WING _____	R-C 08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONARCH DBA UMAR-GIVENS	650 BARRETT LANE ASHEVILLE, NC 28803

(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 105	Continued From page 6 dated 7/23/24. -"I do" believe the policy was followed regarding admission assessments because Client #4 was "...moving (discharged) from one home (Sister Facility A) to another...[Sister Facility A's QP] met with me, current QP (TL/QP) and staff to make sure it (current placement) would be appropriate." Client #4 was admitted on 7/22/24 and the RD/QP completed the admission assessment on 7/23/24 after admission. This deficiency is cross referenced into 10A NCAC 27G .0203 Competencies of Qualified Professionals and Associate Professionals (V109) for a Type A1 rule violation and must be corrected within 23 days.	V 105		
V 108	27G .0202 (F-I) Personnel Requirements 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 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	V 108	The site will have onsite QP support weekly, from Residential Director or QP designee, to provide ongoing support and supervision. To ensure staff are utilizing their person specifics training to meet the needs of the clients. Implementation: 8/30/24 Ongoing The QP/ Residential Team Lead at time of survey is no longer with Monarch. Director of Nursing verified Residential Manager competency on 8/16/2024 in use of Hoyer Lift to support training of staff. All new staff will be trained and demonstrate competency in use of Hoyer lift proior to working with individual #1. Ongoing	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL011-446	A. BUILDING: _____ B. WING _____	R-C 08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONARCH DBA UMAR-GIVENS	650 BARRETT LANE ASHEVILLE, NC 28803

(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 108	Continued From page 7 including seizure management, currently trained to provide cardiopulmonary resuscitation and 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. (i) The governing body shall develop and implement policies and procedures for identifying, reporting, investigating and controlling infectious and communicable diseases of personnel and clients. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure staff were trained to meet the needs of the clients, affecting 5 of 6 audited staff (#1, #2, #3, #4 and the House Manager (HM)). The findings are: Review on 7/22/24 of Staff #1's personnel record revealed: -Date of hire: 1/9/24. -Position: Direct Support Professional (DSP). -No documented training for Client #1's care including Hoyer lift, transferring, putting on and taking off AFOs, taking on and taking off toe spacers, assisting with toileting, ensuring skin integrity, dietary limitations and needs, and assisting with bathing for non-ambulatory clients. Review on 7/22/24 of Staff #2's personnel record revealed: -Date of hire: 5/28/24. -Position: DSP. -No documented training for Client #1's care	V 108	All staff recieve person-specific training on individual #1 including medical needs, adaptive equipement, chair positioning, dietary needs. Training will be provided by Residenital Director or Residential Manager and documented in Threap. All staff to be trained by 9/5/24. Residential Manager will monitor with Hoyer Lift competency checklist and adaptive equipment checklist three times weekly to support continued staff competency. Implementation: 8/30/24 Ongoing VP Operations, in consultation with OT, created task analysis for 2-person transfer. Staff were in-serviced on task-analysis on 08/20/2024 and utilized 2 person transfer until 9/3/2024 Grab bar has been installed on right side of toilet on 9/3/2024. QP completes weekly onsite observations of Direct Support Professionals to support continued competency in skills to support the people we serve. Residential Director or designee will complete Residential Services Observation form. Implementation: 8/30/24 Ongoing	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL011-446	A. BUILDING: _____ B. WING _____	R-C 08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONARCH DBA UMAR-GIVENS	650 BARRETT LANE ASHEVILLE, NC 28803

(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 108	Continued From page 8 including Hoyer lift, transferring, putting on and taking off AFOs, taking on and taking off toe spacers, assisting with toileting, ensuring skin integrity, dietary limitations and needs, and assisting with bathing for non-ambulatory clients. Review on 7/24/24 of Staff #3's personnel record revealed: -Date of hire: 2/19/24. -Position: DSP. -No documented training for Client #1's care including Hoyer lift, transferring, putting on and taking off AFOs, taking on and taking off toe spacers, assisting with toileting, ensuring skin integrity, dietary limitations and needs, and assisting with bathing for non-ambulatory clients. Review on 7/26/24 of Staff #4's personnel record revealed: -Date of hire: 4/19/24. -Position: DSP. -No documented training for Client #1's care including Hoyer lift, transferring, putting on and taking off AFOs, taking on and taking off toe spacers, assisting with toileting, ensuring skin integrity, dietary limitations and needs, and assisting with bathing for non-ambulatory clients. Review on 7/22/24 of the HM's personnel record revealed: -Date of hire: 10/30/23. -No documented training for Client #1's care including Hoyer lift, transferring, putting on and taking off AFOs, taking on and taking off toe spacers, assisting with toileting, ensuring skin integrity, dietary limitations and needs, and assisting with bathing for non-ambulatory clients. Interviews on 7/18/24 and 7/24/24 with Staff #1 revealed:	V 108	This page intentionally left blank	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL011-446	A. BUILDING: _____ B. WING _____	R-C 08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONARCH DBA UMAR-GIVENS	650 BARRETT LANE ASHEVILLE, NC 28803

(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 108	Continued From page 9 -Staff had received "...no trainings on her (Client #1's) assistance needs...no training prior to her being admitted." -"We (staff) aren't trained in transfers..." -"[RD/QP] or [TL/QP] didn't do any of the training or demonstrating for [Client #1's] transferring... [RD/QP] was in the office and on her computer." -"When I got there (7/15/24)...staff just talking amongst (other) staff about what to do (about Client #1's needs and level of assistance)...basically just us trying to figure it out on our own." -"...Staff are not trained (in transfers and Client #1's needs)..." Interviews on 7/18/24 and 7/24/24 with Staff #2 revealed: -"Nobody trained us in the Hoyer lift, we took tips from each other about what helps and what is best." -"The [RD/QP] did not demonstrate the transfers (for Client #1)." -"[Client #1's Guardian] gave us (staff) the ins and outs for her (Client #1), what [Client #1] can handle." -"[RD/QP] didn't review client specifics or admission screening info (information) with staff for [Client #1]." -Client #1's guardian "...was talking staff through what to do for [Client #1]." -"[Client #1] gags a lot...should have been training (for assistance need at mealtimes). -"A lot of us had concerns about proper training..." Interview on 7/24/24 with Staff #3 revealed: -Was on shift by himself from 7/16/24-7/18/24, 12am-6am. -Was "...under the impression that she (Client #1) was partially independent but that wasn't the case."	V 108	This page intentionally left blank	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL011-446	A. BUILDING: _____ B. WING _____	R-C 08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONARCH DBA UMAR-GIVENS	650 BARRETT LANE ASHEVILLE, NC 28803

(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 108	Continued From page 10 -"When [Client #1] got here I was going into everything blind...on shift (7/16/24) not knowing anything..." -There were "...no instructions on what to do (for Client #1)." -Did not receive training on Client #1's needs or level of assistance. "...no training...no training or instructions on what to do (for Client #1)." -Client #1 needs "...total assistance with everything...not much she can do on her own." -The "...manager (HM) went over [Client #1's] assistance needs Tuesday morning (7/16/24) when (HM) arrived on shift..." -"I addressed concerns about the difficulty with transfers and lack of training with my manager (HM)...she told [RD/QP] and [RD/QP] said that staff can handle it...staff will get used to it." Interview on 7/24/24 with Staff #4 revealed: -Was on shift by herself from 7/15/2-7/18/24, 9pm to 12am. -"Knew 2 months ago (prior to Client #1's admission) that someone was coming that was in a wheelchair and needed assistance using the bathroom, but the information was very limited." -"No training about her (Client #1) medical equipment or level of assistance needed." -"[RD/QP] didn't do any training or demonstrating (for Client #1's care)." -"I was offered some trainings by the [Executive Vice President (EVP)]...she reached out asking if we needed to do any trainings (after Client #1 was admitted, before the survey was opened)...let [EVP] know about the Heart valve issue (for Client #1)...[EVP] asked if she can get me extra training on it." -"I followed up with [RD/QP] about the extra training for the heart valve and [RD/QP] didn't seem to understand why I would want it...told me to just call 911."	V 108	This page intentionally left blank	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL011-446	A. BUILDING: _____ B. WING _____	R-C 08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONARCH DBA UMAR-GIVENS	650 BARRETT LANE ASHEVILLE, NC 28803

(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 108	Continued From page 11 Interview on 7/19/24 with the HM revealed: -The RD/QP "didn't review" client specifics or admissions screening information. -"Wasn't trained on her (Client #1) needs." -Was not trained on using a Hoyer lift. -Staff need training on "...Hoyer lift, transferring for toileting, eating, putting on leg braces, wrist brace for left wrist, and toe spacers for both feet." -Trained staff the day Client #1 was admitted and with staff as they arrived on shift the following day by, "...visual training...showed them how it goes...typed up a document with the steps for each task." -Client #1 needed assistance with eating by, "...food needs to be cut into small pieces, needs verbal cues to prompt her to eat, verbal cues for everything or else she'll sit there...didn't know she needed assistance eating until she got here." Review on 7/18/24 and 7/23/24 of Client #1's record revealed: -Admission Date: 7/15/24. -Diagnoses: Anxiety Disorder, Unspecified; Hypothyroidism; Cerebral Palsy; Malignant Neoplasm of pituitary gland; Vitamin D Deficiency; Unspecified Asthma (uncomplicated); Moderate Intellectual Developmental Disability (IDD); Dorsalgia, Unspecified; Hypopituitarism; and Other Seasonal Allergic Rhinitis. -Health Risk Assessment from the Local Management Entity/Managed Care Organization (LME/MCO) dated 4/8/24: -"[Client #1] is non-ambulatory and needs complete and safe assistance with all transfers in and out of bed...and needs complete assistance with taking off and putting on all her clothing." -"Requires full staff support in the bathroom." -"She needs complete assistance to come to a seated position to get back out of bed."	V 108	This page intentionally left blank	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL011-446	A. BUILDING: _____ B. WING _____	R-C 08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONARCH DBA UMAR-GIVENS	650 BARRETT LANE ASHEVILLE, NC 28803

(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 108	Continued From page 12 -"Requires assistance with putting on her braces and taking them off daily. She also has a variety of toe spacers she wears at night." -"Food needs to be cut up in manageable pieces. She needs to be monitored while she is eating to prevent issues with choking." -Individual Support Plan from the LME/MCO dated 8/1/24: -"Requires full physical support to have all of her personal needs met." -"Due to having rods in her back, [Client #1] has to lay in the same position on her back throughout the night and is dependent on caregivers to transfer her or move her as she is unable to do this by herself." -"Has instances of vomiting that can come on suddenly day and night and it is imperative that caregivers are with her at all times when this is occurring to get her into a sitting position so that she does not aspirate on the vomit." -"Requires supervision when she is attempting to use the restroom..." -"Requires hands on assistance with all transfers and safety precautions in place as she fears falling." -"Will also need ongoing assistance with her incontinence supplies to ensure that she maintains skin integrity." -"Needs to eat small bites at mealtimes so that she does not aspirate. [Client #1] can feed herself but her food must be cut up into bite size pieces and assistance when is unable to get certain foods to her mouth." -Admission Assessment dated 7/23/24 completed by the Residential Director/Qualified Professional (RD/QP) revealed: -"Needs full assistance with most activities of daily living (ADL)." -"Is not ambulatory. She uses a power wheelchair. She needs complete and safe	V 108	This page intentionally left blank	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL011-446	A. BUILDING: _____ B. WING _____	R-C 08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONARCH DBA UMAR-GIVENS	650 BARRETT LANE ASHEVILLE, NC 28803

(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 108	Continued From page 13 assistance with all transfers. Staff are to assist with personal care and hygiene needs. A Hoyer lift has been ordered for the group home. Once [Client #1] is lying down she is not able to roll over or sit up. She has had rods in her back since childhood, related to her Cerebral Palsy (CP). [Client #1] uses a toe separator and ankle-foot orthoses (AFOs). At night, she uses a hand splint on her left hand to prevent contractures. [Client #1] uses incontinence briefs but can also tell staff when she needs assistance to transfer to the toilet and use the bathroom. [Client #1] uses a custom shower chair. Staff must fully assist [Client #1] with bathing to ensure hygiene and prevent skin breakdown. [Client #1] can brush her teeth but needs assistance from staff with hard-to-reach places. [Client #1] has had vomiting issues related to her seasonal allergies in the past. She must be monitored at night to ensure she does not aspirate. She must be immediately sat up if she is vomiting." Interview on 7/19/24 with Client #1 revealed: -Limited information as she repeated back what was asked of her and also "forgot" what she was discussing. Interviews on 7/23/24 and 7/24/24 with Client #1's Guardian revealed: -Client #1 "...is in a wheelchair all day long...can transfer with help to the commode (toilet)...left arm is affected so can't manipulate her clothes to use the bathroom and needs help cleaning after...has to be put in bed, lifted into bed, dressed and undressed...needs something she can hold on to and bite, she cannot prepare her own food." -Client #1 is at risk for aspiration, "...she has rods down her back...food has to be chopped in bite size pieces...she cannot sit herself up or roll	V 108	This page intentionally left blank	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL011-446	A. BUILDING: _____ B. WING _____	R-C 08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONARCH DBA UMAR-GIVENS	650 BARRETT LANE ASHEVILLE, NC 28803

(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 108	Continued From page 14 herself over." -"...demonstrated with staff what it looks like to do a transfer...but I wasn't much help because I use a walker." -"...talked with staff somewhat about bathroom routine." -"[Client #1] wears AFOs...from below her knees to her feet." -"[Client #1] wears a brace on her left hand at night...her hand is very stressed, and it helps make it relaxed and opened." -"[Client #1] wears toe spacers on both feet...keep her toes from curling under...keep her toes evenly spaced...right toe knuckle fused together...top of her big toe gets real tight." Interview on 8/1/24 with Client #1's Care Coordinator revealed: -Did an unannounced visit to the facility on 7/29/24. -"Noticed [Client #1's] left foot was strapped in the incorrect position...foot was off the pedal little less than halfway off...needs to be completely back against the foot petal rest and strapped." -Sent an email on 7/30/24 in the morning to the House Manager, RD/QP and Team Leader/Qualified Professional (TL/QP) about Client #1's foot being placed and strapped wrong in her chair, "...didn't receive an email response back from [RD/QP] or [TL/QP]." Interview on 8/5/24 with Client #1's Occupational Therapist (OT) revealed: -Visited the facility on 7/31/24 and did a full evaluation with Client #1. -The facility's method of "...transferring is super unsafe." -"...the facility staff didn't know anything about her seat functions." -"Using her seat functions and repositioning are	V 108	This page intentionally left blank	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL011-446	A. BUILDING: _____ B. WING _____	R-C 08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONARCH DBA UMAR-GIVENS	650 BARRETT LANE ASHEVILLE, NC 28803

(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 108	Continued From page 15 very important to prevent wounds and redness." -She created a document referencing Client #1's seat functions and positioning and provided it to the facility staff. -She asked staff questions that they didn't know the answers to, "...a lot of info that they would say they didn't know...staff had very limited info on her." -Client #1's toe spacers and correct positioning are important because it "...prevents skin breakdown...any long-term tone toes start to curl up and skin breaks...so decreases contractures and skin breakdown." -"...need to keep feet strapped down so she (Client #1) doesn't break her leg...need to be strapped correctly in case of spasm and kicks leg out and hits something." -She was going to go back to the facility to "go through the transfers" with staff again and "talk about safety." Interview on 7/19/24 with TL/QP revealed: -Responsibilities were "...basically overseeing all the staff there (at the facility)...completing tasks...paperwork." -"Came to the facility once" since being hired on 5/1/24. -Client #1 "needs round the clock care from the staff...assist him (her) with being more mobile through staff assistance." -"I believe that it was [RD/QP]" who provided training for Client #1's needs. Interview on 7/23/24 with the RD/QP revealed: -"...person specific program in [online information system] that goes over the client's needs...snapshot of assessments...reviewed with each of the staff...manager (HM) does follow up and ongoing training with staff." -"...QP (TL/QP) is responsible for client specific	V 108	This page intentionally left blank	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL011-446	A. BUILDING: _____ B. WING _____	R-C 08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONARCH DBA UMAR-GIVENS	650 BARRETT LANE ASHEVILLE, NC 28803

(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 108	Continued From page 16 trainings." -She has been "...helping with QP (TL/QP) duties at that home (facility)." -She was fulfilling TL/QP duties when Client #1 was admitted on 7/15/24. -"...went through the client specific form with staff...her guardian and I demonstrated transfers for staff (for Client #1)." -"...did person specific training (for Client #1) with different staff throughout the day (7/15/24)." -Training for Client #1's needs were completed on 7/15/24, "...dietary needs in person specific and reviewed with staff...3 of the main staff (Staff #1, Staff #2 and the HM on site with guardian during admission to go over how a transfer goes." -"Not formerly" trained to use a Hoyer lift. This deficiency is cross referenced into 10A NCAC 27G .0203 Competencies of Qualified Professionals and Associate Professionals (V109) for a Type A1 rule violation and must be corrected within 23 days.	V 108	This section intentionally left blank V109 VP of Operations will inservice Residential Director on knowledge, skills, and abilities required by the people we support at Givens. Implementation: 8/30/24 Ongoing	
V 109	27G .0203 Privileging/Training Professionals 10A NCAC 27G .0203 COMPETENCIES OF QUALIFIED PROFESSIONALS AND ASSOCIATE PROFESSIONALS (a) There shall be no privileging requirements for qualified professionals or associate professionals. (b) Qualified professionals and associate professionals shall demonstrate knowledge, skills and abilities required by the population served. (c) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence. (d) Competence shall be demonstrated by exhibiting core skills including:	V 109	VP will re-inservice the Director on the need to ensure staff are trained in person-specific needs. Trainings will include use of Hoyer lift, transferring, putting on and taking off AFOs, taking on and taking off toe spacers, assisting with toileting, ensuring skin integrity, dietary limitations and needs, and assisting with bathing for non-ambulatory clients. Implementation: 8/30/24 Ongoing	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL011-446	A. BUILDING: _____ B. WING _____	R-C 08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONARCH DBA UMAR-GIVENS	650 BARRETT LANE ASHEVILLE, NC 28803

(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 109	Continued From page 17 (1) technical knowledge; (2) cultural awareness; (3) analytical skills; (4) decision-making; (5) interpersonal skills; (6) communication skills; and (7) clinical skills. (e) Qualified professionals as specified in 10A NCAC 27G .0104 (18)(a) are deemed to have met the requirements of the competency-based employment system in the State Plan for MH/DD/SAS. (f) The governing body for each facility shall develop and implement policies and procedures for the initiation of an individualized supervision plan upon hiring each associate professional. (g) The associate professional shall be supervised by a qualified professional with the population served for the period of time as specified in Rule .0104 of this Subchapter. This Rule is not met as evidenced by: Based on observation, record review and interview, 2 of 2 qualified professionals (Residential Director/Qualified Professional (RD/QP) and Team Leader/Qualified Professional (TL/QP) failed to demonstrate the knowledge, skills, and abilities required by the population served. The findings are: Cross Reference: 10A NCAC 27G .0201 Governing Body Policies (V105). Based on record review and interview, the facility failed to implement their written policies on screening and	V 109	VP of Operations will have supervision with Residential Director 2x weekly. Job Duties checklist of Residential Team Lead (QP) and Residential Director will be discussed in supervision. Implementation: 8/30/24 Ongoing VP of Operations will monitor completion of QP tasks by completing checks of random sampling of records. Implementation: 8/30/24 Ongoing Residential Team Lead/QP at time of survey is no longer with Monarch.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL011-446	A. BUILDING: _____ B. WING _____	R-C 08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONARCH DBA UMAR-GIVENS	650 BARRETT LANE ASHEVILLE, NC 28803

(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 109	Continued From page 18 admission assessments for 2 of 4 audited clients (#1 and #4). Cross Reference: 10A NCAC 27G .0202 Personnel Requirements (V108). Based on record review and interview, the facility failed to ensure staff were trained to meet the needs of the clients, affecting 5 of 6 audited staff (#1, #2, #3, #4 and the House Manager (HM)). Cross Reference: 10A NCAC 27G .0205 Assessment/Treatment/Habilitation or Service Plan (V111). Based on record review and interview, the facility failed to ensure strategies were developed to address client needs prior to the delivery of services for 2 of 4 audited clients (#1 and #4). Cross Reference: 10A NCAC 27G .5602 Staff (V290). Based on record review and interview, the facility failed to ensure staffing to meet the individualized needs of the clients served. Review on 7/24/24 of the TL/QP's personnel record revealed: -Date of hire: 5/1/24. -Job Description dated 5/6/24: -"Provide initial and ongoing assessment." -"Participate in team meetings with other providers and natural supports as needed and facilitate development of person-centered plan." -"Ensure requests for services are made considering eligibility, continued stay and discharge criteria for the service definition." -"Ensure staff are appropriately trained regarding plans and related programs and demonstrate an understanding of specific plan components." -"Maintain the records of the individuals supported."	V 109	This page intentionally left blank	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL011-446	A. BUILDING: _____ B. WING _____	R-C 08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONARCH DBA UMAR-GIVENS	650 BARRETT LANE ASHEVILLE, NC 28803

(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 109	Continued From page 19 -"Use a range of communication skills and strategies to establish a mutual relationship with the individual, staff, co-workers, supervisors, other stakeholders and people who are important to the individuals receiving services." -"Take responsibility for hiring, discipline, firing, training, and performance appraisals where appropriate." -"Maintain a safe working environment for employees and people receiving services." -"Schedule and participate in on-call coverage." Review on 7/22/24 of the RD/QP's personnel record revealed: -Date of hire: 7/25/22. -Job Description dated 12/26/23: -"Develops, plans, organizes, implements, and coordinates operations in a manner that promotes growth and achievement for individuals supported, staff, agency, community, and all other stakeholders." -"Develop and present training related to residential services and operations, ensuring staff meet regulatory training timeframes." -"Maintain positive working relationships within the communities served, including individuals, families, staff, monitoring and licensing agencies, organizations, funders, funding sources and other stakeholders." -"Maintain trainings as required and requested." -"Demonstrate knowledge of and comply with all agency policies and procedures." Interview on 7/23/24 with Client #1's Guardian revealed: -"Didn't meet [TL/QP], wasn't there when we came (7/15/24)."	V 109	This page intentionally left blank	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL011-446	A. BUILDING: _____ B. WING _____	R-C 08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONARCH DBA UMAR-GIVENS	650 BARRETT LANE ASHEVILLE, NC 28803

(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 109	Continued From page 20 Interview on 8/1/24 with Client #1's Care Coordinator revealed: -She had asked the TL/QP 3 separate times to sign the Provider Change Document and Annual Plan of Care prior to Client #1's admission to the facility. -"Mostly communicating with [RD/QP] and [House Manager (HM)]. [Client #1's Guardian] told me she hasn't met [TL/QP]...(he) wasn't there on 7/15/24 when [Client #1] was admitted." Interviews on 7/18/24 and 7/24/24 with Staff #1 revealed: -"Never met [TL/QP], couldn't tell you what he looks like." Interviews on 7/18/24 and 7/24/24 with Staff #2 revealed: -Concerns about training and staffing for Client #1's needs were brought up to RD/QP and she felt as if they were "...kind of brushed off." -"Have not heard from [TL/QP]..." -"Have seen [TL/QP] one time...(TL/QP) came last month some time...towards the end of June...haven't heard from him at all since." Interview on 7/24/24 with Staff #3 revealed: -Had not met or had any interactions with the TL/QP since he was hired. -Has not met the RD/QP. -Did not feel comfortable addressing concerns with the RD/QP and feels as though "...she ignores/brushes off" when staff asked for help. Interview on 7/24/24 with Staff #4 revealed: -"...I thought for sure someone would come by and see if the facility would support [Client #1]." -Had not met the TL/QP, "honestly, forgot about him."	V 109	This page intentionally left blank	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL011-446	A. BUILDING: _____ B. WING _____	R-C 08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONARCH DBA UMAR-GIVENS	650 BARRETT LANE ASHEVILLE, NC 28803

(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 109	Continued From page 21 Interviews on 7/19/24, 7/25/24, and 8/6/24 with the HM revealed: -"Team Lead (TL/QP) only visited (the facility) once since being hired (on 5/1/24)." Interview on 7/19/24 with the TL/QP revealed: -"Came to the facility once" since being hired on 5/1/24. Interview on 7/23/24 with the RD/QP revealed: -Was responsible for supervising the TL/QP. Review on 7/19/24 of the 1st Plan of Protection (POP) dated 7/19/24 written by the RD/QP revealed: -"What immediate action will the facility take to ensure the safety of the consumers in your care? Immediately (7/19/2024), 2 staff will be on shift at all times when the people supported are home. 1 sleepover and 1 awake staff are scheduled overnight, and 2 awake staff while people supported are awake. The staffing schedule over the next 7 days is attached. This Director will ensure this staffing pattern remaines in place while the needs of the indivudals require. Describe your plans to make sure the above happens. Givens (facility) management is utilizing support from other homes in addition to scheduling Over Time for staff assigned to to Givens. There are ongoing efforts from the operations and recruiting teams to indentify and train additional staff. Occupational Therapist (OT) referral has been made to determine if increased independence can be gained for person supported [Client #1] who moved into the home 7/15/2024. During intake assessments it was reported that at home she supported by one staff or natrual support for all transfers. Long term staffing patterns will be consistent with the needs	V 109	This page intentionally left blank	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL011-446	A. BUILDING: _____ B. WING _____	R-C 08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONARCH DBA UMAR-GIVENS	650 BARRETT LANE ASHEVILLE, NC 28803

(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 109	Continued From page 22 of the indivudals in the home as assessed by medical professionals." Review on 7/31/24 of the 2nd Plan of Protection (POP) dated 7/30/24 written by the Vice President (VP) of Operations of the UMAR Division (Licensee) revealed: -"What immediate action will the facility take to ensure the safety of the consumers in your care? 1. Effective immediately, Residential Team Leader or designee (QP) will be onsite at least once per week. QP will submit staff observation information to the Residential Director and VP of Operations. RD & VP will meet monthly with TL to review. 2. All UMAR Division Team Leaders & Directors will be in-serviced by the VP of Operations on admission policies & procedures as well as admission processes by 8/6/2024. 3. Effective immediately, the Residential Manager will retrain all staff on the use of the Hoyer lift as they report to shift. 4. The Residential Manager will complete shift observation & document staff competency in use of Hoyer lift. Three (3) observations per week will be documented starting 8/5/2024 for the next 2 months. 5. The VP of Operations will meet with the Education department to review options for Hoyer lift module training by 9/1/2024. 6. The UMAR Division will also assess the team to determine if additional Team Leader positions would be warranted to support the needs of the people we serve by 8/5/2024. 7. Plan of Protection was previously submitted & implemented to address staffing pattern for the support needs of new admission. Additional positions have been posted and recruitment is actively occurring. 8. OT evaluation for new admission is scheduled for 7/31/2024. Evaluation is being completed to determine support needs during transfers. Describe your plans to make sure the above happens. VP of	V 109	This page intentionally left blank	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL011-446	A. BUILDING: _____ B. WING _____	R-C 08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONARCH DBA UMAR-GIVENS	650 BARRETT LANE ASHEVILLE, NC 28803

(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 109	Continued From page 23 Operations will ensure implementation for each item noted above with the support of the EVP-COO of the UMAR Division." Client #1 was diagnosed with Moderate IDD, Anxiety Disorder, Hypothyroidism, Cerebral Palsy, Malignant Neoplasm of the Pituitary Gland, Asthma, Dorsalgia, Hypopituitarism, Season Allergic Rhinitis and Vitamin D Deficiency. Client #4 was diagnosed with Mild IDD, Dysthymia, HNO5 Thyroid, and Psychological Factor Hypothyroidism. The RD/QP and TL/QP did not complete the required screening and admission assessments for Clients #1 and #4 prior to admission. As a result of the lack of screening and admission assessments, strategies to meet the needs of the clients were not developed and staff were left not knowing how to provide the required care for Clients #1 and #4. Client #1 had no functional use of her left upper extremity and used a motorized chair she controlled with her right hand. Client #1 required full physical support from staff to have all of her personal needs met and required at least 2 staff to complete transfers in the facility. The RD/QP and TL/QP did not ensure staffing ratios to meet the individualized needs for Client #1 by having only one staff scheduled at times from 7/15/24-7/18/24. Client #1 required a minimum of 2 staff for safe transfers and the use of the Hoyer lift. The RD/QP and TL/QP did not provide staff with the training needed to support Client #1's ambulatory needs, adaptive equipment, and personal care. Client #1 was evaluated by an OT 16 days after admission. Upon evaluation, the OT determined the facility staff did not have the training or supports to care for Client #1 in a safe manner. The TL/QP had only been to the facility once since 5/1/24, was not present for Client #1's or Client #4's admission and did not communicate	V 109	This page intentionally left blank	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL011-446	A. BUILDING: _____ B. WING _____	R-C 08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONARCH DBA UMAR-GIVENS	650 BARRETT LANE ASHEVILLE, NC 28803

(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 109	Continued From page 24 with staff about what to expect for either client. This deficiency constitutes a Type A1 rule violation for serious neglect and must be corrected within 23 days.	V 109	This section intentionally left blank	
V 111	27G .0205 (A-B) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (a) An assessment shall be completed for a client, according to governing body policy, prior to the delivery of services, and shall include, but not be limited to: (1) the client's presenting problem; (2) the client's needs and strengths; (3) a provisional or admitting diagnosis with an established diagnosis determined within 30 days of admission, except that a client admitted to a detoxification or other 24-hour medical program shall have an established diagnosis upon admission; (4) a pertinent social, family, and medical history; and (5) evaluations or assessments, such as psychiatric, substance abuse, medical, and vocational, as appropriate to the client's needs. (b) When services are provided prior to the establishment and implementation of the treatment/habilitation or service plan, hereafter referred to as the "plan," strategies to address the client's presenting problem shall be documented.	V 111	All UMAR Division Team Leaders and Directors were in-serviced 8/13/2024 on the admission process by VP of Operations, UMAR Division. Prior to any new admissions, Team Leads will complete Admissions Checklists in its entirety and VP of Operations will review to ensure completion. Implementation: 8/30/24 Ongoing Needs identified in assessments will be addressed in the treatment plan. Assessments will be reviewed during 2x weekly supervision of Residential Director with VP of Operations. Implementation: 8/30/24 Ongoing	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL011-446	A. BUILDING: _____ B. WING _____	R-C 08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONARCH DBA UMAR-GIVENS	650 BARRETT LANE ASHEVILLE, NC 28803

(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 111	Continued From page 25 This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure strategies were developed to address client needs prior to the delivery of services for 2 of 4 audited clients (#1 and #4). The findings are: Review on 7/18/24 and 7/23/24 of Client #1's record revealed: -Admission Date: 7/15/24. -Diagnoses: Anxiety Disorder Unspecified; Hypothyroidism; Cerebral Palsy; Malignant Neoplasm of pituitary gland; Vitamin D Deficiency; Unspecified Asthma (uncomplicated); Moderate Intellectual Developmental Disability (IDD); Dorsalgia, Unspecified; Hypopituitarism; and Other Seasonal Allergic Rhinitis. -No evidence of an assessment completed by the licensee with strategies in place for Client #1's needs prior to admission. Refer to Tag V108 for Client #1's Health Risk Assessment dated 4/8/24, Individualized Support Plan dated 7/1/24, and the facility's Admission Assessment dated 7/23/24 identifying Client #1's needs. Interview on 7/19/24 with Client #1 revealed: -Limited information as she repeated back what was asked of her and also forgot what she was discussing. Interview on 7/26/24 Client #1's Care Coordinator	V 111	This page intentionally left blank	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL011-446	A. BUILDING: _____ B. WING _____	R-C 08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONARCH DBA UMAR-GIVENS	650 BARRETT LANE ASHEVILLE, NC 28803

(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 111	Continued From page 26 revealed: -"Sent an invite 6/20/24 for a virtual meeting about [Client #1's] needs, annual plan...making sure had everything in Annual Plan of Care laid out to discuss and if anything else was needed." -The "...meeting (virtual meeting) was scheduled for 6/26/24 at 11:30am, invited [Team Leader/Qualified Professional (TL/QP)], [House Manager (HM)], [Client #1's Guardian], and [Residential Director/Qualified Professional (RD/QP)]." -"[HM] was the only one that came to the 6/26/24 meeting and we went over a lot, she had a lot of questions...it was such a time crunch we couldn't re-schedule...if [TL/QP] needed to meet with us another time he could." -"...main concern [Client #1]...so important to her to feel safe." Review on 7/23/24 of Client #4's record revealed: -Admission Date: 7/22/24. -Diagnoses: Dysthymia (Unspecified Depressive Disorder), Mild IDD, HNO5 Thyroid (Thyroid nodule), and Psychological Factor Hypothyroidism. -No evidence of an updated assessment completed by the licensee with strategies in place for Client #4's needs prior to being admitted to the facility. Refer to Tag V108 for Client #4's facility Admission Assessment dated 7/23/24 identifying Client #4's needs. Interviews on 7/18/24 and 7/24/24 with Staff #1 revealed: -"When I got there (to the facility on 7/15/24 when Client #1 was admitted)...staff just talking amongst (other) staff about what to do (about Client #1's needs and level of	V 111	This page intentionally left blank	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL011-446	A. BUILDING: _____ B. WING _____	R-C 08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONARCH DBA UMAR-GIVENS	650 BARRETT LANE ASHEVILLE, NC 28803

(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 111	Continued From page 27 assistance)...basically just us trying to figure it out on our own." -On the day Client #1 was admitted, "...the only assessment we (staff) had was a printed-out form from her (Client #1) application through [Local Management Entity/Managed Care Organization] who has handled her case." Interview on 7/24/24 with Staff #2 revealed: -There was "...no communication from the [RD/QP] or [TL/QP] about admission info (for Client #1)." -Client #1's guardian "...was talking staff through what to do for [Client #1] (on 7/15/24)." -"...we (staff) had to figure out what was best for how staff can assist her (Client #1)." -"[Client #1] just doesn't eat much...she gags a lot." -The information provided regarding Client #4 was "...only that she was independent...gave us a small run down...likes and dislikes." Interview on 7/24/24 with Staff #3 revealed: -Was on shift by himself from 7/16/24-7/18/24, 12am-6am. -"...under the impression that she (Client #1) was partially independent but that wasn't the case." -"When [Client #1] got here I was going into everything blind...on shift (7/16/24) not knowing anything..." -There were "...no instructions on what to do (for Client #1)." -Client #1 needs "...total assistance with everything...not much she can do on her own." -The "...manager (HM) went over [Client #1's] assistance needs Tuesday morning (7/16/24) when (HM) arrived on shift..." -"That first morning took us about an hour and a half to get [Client #1] out of bed and to the breakfast table...just me and my manager (HM)	V 111	This page intentionally left blank	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL011-446	A. BUILDING: _____ B. WING _____	R-C 08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONARCH DBA UMAR-GIVENS	650 BARRETT LANE ASHEVILLE, NC 28803

(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 111	Continued From page 28 left to figure it out...struggling with transferring her from the bed to Hoyer lift, then Hoyer lift to the chair." Interview on 7/24/24 with Staff #4 revealed: -Was on shift by herself from 7/15/2-7/18/24, 9pm to 12am. -"...let [RD/QP] know of my concerns that her plan had her a risk for choking at night and the heart valve potentially going out...[RD/QP] said to call the police." -"I was really nervous when someone tells me that [Client #1] can potentially die...risk of vomiting." -"I followed up with [RD/QP]...for the heart valve...told me to just call 911." Interview on 7/19/24 with the HM revealed: -Client #1 needed assistance with eating by, "...food needs to be cut into small pieces, needs verbal cues to prompt her to eat, verbal cues for everything or else she'll sit there...didn't know she needed assistance eating until she got here." Interview on 7/19/24 with the TL/QP revealed: -"Came to the facility once" since being hired on 5/1/24. Interview on 7/23/24 with the RD/QP revealed: -The TL/QP was responsible for creating the "initial" treatment plans with strategies in place for client needs and "updates" to the treatment plans. This deficiency is cross referenced into 10A NCAC 27G .0203 Competencies of Qualified Professionals and Associate Professionals (V109) for a Type A1 rule violation and must be corrected within 23 days.	V 111	This page intentionally left blank	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL011-446	A. BUILDING: _____ B. WING _____	R-C 08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONARCH DBA UMAR-GIVENS	650 BARRETT LANE ASHEVILLE, NC 28803

(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 117	Continued From page 29	V 117		
V 117	27G .0209 (B) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (b) Medication packaging and labeling: (1) Non-prescription drug containers not dispensed by a pharmacist shall retain the manufacturer's label with expiration dates clearly visible; (2) Prescription medications, whether purchased or obtained as samples, shall be dispensed in tamper-resistant packaging that will minimize the risk of accidental ingestion by children. Such packaging includes plastic or glass bottles/vials with tamper-resistant caps, or in the case of unit-of-use packaged drugs, a zip-lock plastic bag may be adequate; (3) The packaging label of each prescription drug dispensed must include the following: (A) the client's name; (B) the prescriber's name; (C) the current dispensing date; (D) clear directions for self-administration; (E) the name, strength, quantity, and expiration date of the prescribed drug; and (F) the name, address, and phone number of the pharmacy or dispensing location (e.g., mh/dd/sa center), and the name of the dispensing practitioner. This Rule is not met as evidenced by: Based on observation, record review, and interview the facility failed to maintain pharmacy packing labels as required for each prescription	V 117	All medication not packaged by a pharmacist has been discarded and disposed of properly. All medications are in pharmacy -labeled packaging. On 8/16/2024, UMAR Division VP of Operations, Residential Director, Residential Team Leader, Residential Manager and Givens staff attended Medication Administration Class taught by Director of Nursing for retraining purposes. Training included that only medications properly packaged by pharmacist can be administered by staff. The residential manager will complete medication administration observation of staff 3x weekly. Implementation: 8/30/24 Ongoing Monthly medication room audit will be completed by the Residential Manager. Implementation: 8/30/24 Ongoing	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL011-446	A. BUILDING: _____ B. WING _____	R-C 08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONARCH DBA UMAR-GIVENS	650 BARRETT LANE ASHEVILLE, NC 28803

(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 117	Continued From page 30 drug dispensed for 1 of 4 audited clients (#1). The findings are: Review on 7/18/24 of Client #1's record revealed: Admission Date: 7/15/24. Diagnoses: Anxiety Disorder; Unspecified, Hypothyroidism; Cerebral Palsy; Malignant Neoplasm of pituitary gland; Vitamin D Deficiency; Unspecified Asthma (uncomplicated); Moderate Intellectual Developmental Disability; Dorsalgia, unspecified; Hypopituitarism; and Other Seasonal Allergic Rhinitis. Observation on 7/18/24 at 11:57AM of Client #1's medications revealed: -A purple 7-day medication (med) planner; Sunday through Saturday. -Each day in the planner had unlabeled pills present as follows: Sunday 8 ½ pills; 5 ½ white pills, (including 1 tablet engraved with an "E" on it), 1 grey pill, 1 yellow capsule, and 1 orange pill. Monday, 7 ½ pills; 4 ½ white pills, 1 grey pill, 1 yellow capsule, and 1 orange pill. Tuesday, 6 ½ pills; 3 ½ white pills, 1 grey pill, 1 yellow capsule, and 1 orange pill. Wednesday, 7 pills; 4 whole white pills, 1 grey pill, 1 yellow capsule, and 1 orange pill. Thursday, 7 ½ pills; 4 ½ white pills, 1 tablet marked E, 1 grey pill, 1 yellow capsule, and 1 orange pill. Friday, 7 ½ pills; 4 ½ white pills, 1 tablet marked E, 1 grey pill, 1 yellow capsule, and 1 orange pill. Saturday, 8 pills; 5 white pills, 1 tablet marked E, 1 grey pill, 1 yellow capsule, and 1 orange pill. Interview on 7/18/24 with Staff #1 revealed: -Client #1 was admitted to facility with medications (meds) in a med planner, "had no	V 117	This page intentionally left blank	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL011-446	A. BUILDING: _____ B. WING _____	R-C 08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONARCH DBA UMAR-GIVENS	650 BARRETT LANE ASHEVILLE, NC 28803

(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 117	Continued From page 31 idea what they were." Interview on 7/23/24 with Client #1's Guardian revealed: -Brought a med planner with Client #1's medications on date of admission. Interviews on 7/19/24 and 7/25/24 with the House Manager (HM) revealed: - "[Client #1] was admitted with a pill organizer only ...with pills (in it) ...no labels..." -Client #1 took Excedrin because of chronic headaches. -The facility didn't have an Excedrin order, but staff were administering Excedrin out of the med planner "because that is what mom said and she gets headaches every day ..." -In regard to how staff know they are giving Client #1 the right pill from the med planner (Excedrin), "mom pointed out the Excedrin to me and [Staff #2]." -the rest of the staff would not know (what pill the Excedrin was). - "I did (administered the Excedrin), I didn't want anyone else to do that, so I took responsibility for it ...giving it to her in the morning as scheduled." Interview on 7/19/24 with the Team Leader/Qualified Professional (TL/QP) revealed: -Medication oversight was part of his responsibilities as the QP. -Not aware that Client #1 was admitted to the facility with unlabeled medications in a med planner. Interview on 7/24/24 with the Residential Director/Qualified Professional (RD/QP) revealed: -Was present the day of admission for Client #1 and confirmed that Client #1's guardian brought medications (for Client #1) in a med planner.	V 117	This page intentionally left blank	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL011-446	A. BUILDING: _____ B. WING _____	R-C 08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONARCH DBA UMAR-GIVENS	650 BARRETT LANE ASHEVILLE, NC 28803

(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 117	Continued From page 32 -Created the MAR for Client #1. -Knew Client #1 did not take evening medications and the expectation was that the pharmacy would deliver the meds on the same day (of admission). -Did not know if Client #1's medications were delivered by the pharmacy. -In regard to how she knew staff were giving the right med for Client #1, she was not aware that staff were administering meds (Excedrin) out of the med planner. This deficiency is cross referenced into 10A NCAC 27G .0209 Medication Requirements for a Type A1 rule violation and must be corrected within 23 days.	V 117	This section intentionally left blank	
V 118	27G .0209 (C) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (c) Medication administration: (1) Prescription or non-prescription drugs shall only be administered to a client on the written order of a person authorized by law to prescribe drugs. (2) Medications shall be self-administered by clients only when authorized in writing by the client's physician. (3) Medications, including injections, shall be administered only by licensed persons, or by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer medications. (4) A Medication Administration Record (MAR) of all drugs administered to each client must be kept current. Medications administered shall be recorded immediately after administration. The MAR is to include the following: (A) client's name;	V 118	Pharmacy reviews had been completed every six months by Southern Pharmacy. The manager was not aware of where they were filed. Reviews are now onsite and in EHR for each person supported. Residential Director or QP designee will review MARs and Signed Physician's Orders monthly, and upon any new orders for accuracy and completion. Implementation: 8/30/24 Ongoing All Given's assigned staff from VP of Operations to Direct Support Professionals competed Medication Administration recertification on 8/06/2024.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL011-446	A. BUILDING: _____ B. WING _____	R-C 08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONARCH DBA UMAR-GIVENS	650 BARRETT LANE ASHEVILLE, NC 28803

(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 118	Continued From page 33 (B) name, strength, and quantity of the drug; (C) instructions for administering the drug; (D) date and time the drug is administered; and (E) name or initials of person administering the drug. (5) Client requests for medication changes or checks shall be recorded and kept with the MAR file followed up by appointment or consultation with a physician. This Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure that medications were administered on the written order of a physician affecting 2 of 4 audited clients (#1 and #3) and the facility failed to keep the MARs current for 3 of 4 audited clients (#1, #2, and #3). The findings are: Cross Reference: 10A NCAC 27G .0209 Medication Requirements (V117). Based on observation, record review, and interview the facility failed to maintain pharmacy packing labels as required for each prescription drug dispensed for 1 of 4 audited clients (#1). Cross Reference: 10A NCAC 27G .0209 Medication Requirements (V121). Based on record review and interview, the facility failed to obtain a pharmacist or physicians medication review at least every six months for all clients receiving psychotropic drugs for 1 of 4 audited clients (#3).	V 118	Residential Manager will maintain signed physicians orders with MARs for each person supported. Implementation: 8/30/24 Ongoing All medication not packaged by a pharmacist has been discarded and disposed of properly. All medications are in pharmacy-labeled packaging. Staff will be in serviced on follow-up steps to a Physicians or Provider appointments by Director of Nursing and Residential Director. The importance of service coordination will be discussed to include communication with guardians, day programs, all applicable treatment team members. Implementation: 8/30/24 Ongoing Team Meeting for Client #3 will be scheduled by 09/13/2024with Guardian, PACE program and Monarch QP.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL011-446	A. BUILDING: _____ B. WING _____	R-C 08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONARCH DBA UMAR-GIVENS	650 BARRETT LANE ASHEVILLE, NC 28803

(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 118	Continued From page 34 Cross Reference: 10A NCAC 27G .5603 Operations (V291) Based on record review and interview, the facility failed to ensure service coordination was maintained with other professionals responsible for treatment affecting 1 of 4 audited clients (#3). Review on 7/18/24 of Client #1's record revealed: -Health Risk Assessment (HRA) dated 4/1/24 from the local management entity/managed care organization (LME/MCO) revealed: - "[Client #1] has significant seasonal allergies that affect her all year. They can cause a buildup of mucus and sinus pressure which will result in bad headaches ...can cause severe vomiting ...at risk for aspiration." -No physician orders present for the following medications: -Cetirizine 10 milligram (mg) (allergies) tablet (tab), 1 tab by mouth (PO) every day (QD). -Excedrin Migraine tabs (headache), 1 tab by mouth in the morning for headaches. -Montelukast 10mg (Asthma) tab, 1 tab PO QD. -Vitamin D3 400 Units (10 micrograms (mcg)) (supplement), 1 tab QD. Observation on 7/18/24 at 11:57am of Client #1's medications revealed: -Montelukast 10mg tab, dispensed 7/15/24. -Vitamin D3 400 Units 10mcg, dispensed 7/15/24. Review on 7/18/24 of Client #1's MARs from 7/15/24 to 7/18/24 revealed: -Cetirizine 10 mg (allergies), 1 tab, QD, 0 doses documented as administered. -Excedrin Migraine tablets, 1 tab PO in the morning for headaches, no strength listed on the MAR, 0 doses documented as administered. -Montelukast 10mg tab, handwritten on MAR, no administration instructions, route, or quantity	V 118	Team meetings 8/12/2024 for Client #1 occurred with Care Management, Guardian, Day Services, and VPO, RM from Givens to improve coordination of care. Implementation of Client 1 treatment plan was discussed with training of residential staff. Additionally, collaboration between day program and residential staff in the areas of improved communication, scheduling, transportation, and consistent t raining on both teams in assistance with ADLs.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL011-446	A. BUILDING: _____ B. WING _____	R-C 08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONARCH DBA UMAR-GIVENS	650 BARRETT LANE ASHEVILLE, NC 28803

(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 118	Continued From page 35 noted, 3 doses documented as administered. -Vitamin D3 400 Units 10 mcg, 1 tablet QD, 3 doses documented administered. -6 total doses of medication missed according to the documentation on the MAR. Review on 7/18/24 of Client #2's record revealed: Date of Admission: 9/3/19. Unspecified Intellectual Disabilities, Mild Intellectual Developmental Disability, Lesion on Liver, Hypertension, Borderline Ovarian Tumor, Gait Instability, and Chronic Constipation. -Was admitted to a local hospital on 7/16/24 for a fall at the facility. -Physician Orders dated 1/26/23 included: -Best Fiber Powder 3.8 G (grams) (constipation), 2 Teaspoons (Tsp) PO once daily with 16oz of water. -Calcium 600 + D3 Vitamin Chew (supplement), chew 1 tab PO once daily. -Fluticasone Spray 50 micrograms (mcg) (allergies), spray 1 spray in each nostril once daily. -Ear Drops 6.5% OTIC Solution (Sol) (earwax removal), 4 drops in each ear for 5 minutes every 4 days. -Multivitamin Tab, 1 tab QD. -Vitamin D3 Chew 400 Units, 2 tabs PO once daily. Observation on 7/18/24 at 12:03pm of Client #2's medications revealed: -Best Fiber Powder 3.8 G, not present in the facility. -Calcium 600 + D3 Vitamin Chew, dispensed 7/11/24. -Fluticasone Spray 50mcg, dispensed 5/9/24. -Ear Drops 6.5% OTIC Sol (Debrox), dispensed 10/12/23. -Multivitamin Tablet, dispensed 7/11/24.	V 118	This page intentionally left blank	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL011-446	A. BUILDING: _____ B. WING _____	R-C 08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONARCH DBA UMAR-GIVENS	650 BARRETT LANE ASHEVILLE, NC 28803

(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 118	Continued From page 36 -Vitamin D3 Chew 400 Units, dispensed 7/11/24. Review on 7/18/24 and 7/25/24 of Client #2's MARs from 2/1/24 to 7/16/24 revealed: -Calcium 600 + D Vitamin Chew, Multivitamin, and Vitamin D3 Chew were documented as administered for 30 days in February 2024. -No documentation that Calcium 600 + D Vitamin Chew, Best Fiber Powder, Fluticasone Nose Spray, Multivitamin Tab, and Vitamin D3 were administered on 7/5/24 (6 total doses of medication missed according to MAR). -Ear Drops 6.5% Sol documented as administered: 2 doses in February 2024, 1 dose in March 2024, 0 doses in April and May 2024, 1 dose in June 2024, and 0 doses in July 2024. -Best Fiber Powder was documented as "D" (drug not administered-out of medication "on the MAR from 7/10/24 to 7/16/24. -51 total doses of medication missed according to documentation on the MARs. Review on 7/18/24 of Client #3's record revealed: Date of Admission: 8/1/97. Diagnoses: Mild Intellectual Developmental Disability, Hypertension, Hyperlipidemia, Depression, Anxiety, Osteoporosis, and Seasonal Allergies. -History of cataract surgery. -Physician orders included: -Citalopram 40mg (depression) tab, 1 tab PO QD, ordered 6/19/23. -Famotidine 20mg tab (acid reflux), 1 tab PO QD, ordered 11/16/23. -Loratadine 10mg (allergies) tab, 1 tab PO QD, ordered 11/29/23. -Vitamin D3 5000 Unit (125 MCG Cap), 1 tab PO QD, ordered 10/12/23. -No physician orders present for the following medications:	V 118	This page intentionally left blank	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL011-446	A. BUILDING: _____ B. WING _____	R-C 08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONARCH DBA UMAR-GIVENS	650 BARRETT LANE ASHEVILLE, NC 28803

(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 118	Continued From page 37 -Ofloxacin OP (Ophthalmic) 0.3% (Conjunctivitis) eye drops, 4 times daily (QID). -Prednisone Acetate 1% (Ophthalmic Steroid) eye drops, QID. -Polyethylene Glycol 3350 Powder (Constipation), 1 cap with 8oz of liquid daily for constipation. -Vitamin B-12 1000 mcg (supplement), 1 tab, PO QD for low B-12. -Risperidone 1mg tab (psychosis), 1 tab twice daily (BID) for psychotic symptoms. -Trazodone 100mg tab (sedation/antidepressant), 1 tab at bedtime (QHS). -Trazodone 50mg, 1 tab PO, every 8 hours (Q8H) as needed (PRN). Observation on 7/18/24 at 12:30pm of Client #3's medications revealed: -Citalopram 40mg tab, dispensed 7/11/24. -Loratadine 10mg tab, dispensed 7/11/24. -Polyethylene Glycol 3350 Powder (MiraLAX), dispensed 4/8/24. -Vitamin B-12 1000 mcg tab, dispensed 7/11/24. -Risperidone 1mg tab, dispensed 7/11/24. Review on 7/18/24 and 7/25/24 of Client #3's MARs from 2/1/24 to 7/18/24 revealed: February 2/1/24 to 2/29/24: -Citalopram 40mg 1 tab PO QD, was documented as "D" on 2/21/24 and 2/22/24. -Loratadine 10mg tab, documentation of 30 doses administered in February 2024. -Ofloxacin OP 0.3% (antibiotic drops for eye) handwritten on MAR starting 2/6/24 at 3pm, instill 1 drop into R (right) eye 4 times daily (QID), scheduled 7:00am, 11:00am, 3:00pm, and 7:00pm. - "0" documented on 2/7/24 for day. No documentation on the back of the MAR. -2 out of 4 daily doses documented as	V 118	This page intentionally left blank	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL011-446	A. BUILDING: _____ B. WING _____	R-C 08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONARCH DBA UMAR-GIVENS	650 BARRETT LANE ASHEVILLE, NC 28803

(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 118	Continued From page 38 administered on 2/13/24 and 2/14/24 with a D/C (discontinue) line in ink starting 2/15/24. -Prednisolone Acetate 1%, (steroid eye drops) handwritten on MAR starting 2/6/24 at 3pm, instill 1 drop in to R eye scheduled QID, 7:00am, 11:00am, 3:00pm, and 7:00pm. - "0" documented on 2/7/24 for day. No documentation on the back of the MAR. -2 doses documented as administered on 2/12/24 and 7:00 am and 11:00am. -3 doses documented as administered on 2/13/24 at 7:00am, 3:00pm, and 7:00pm. -Ofloxacin OP 0.3% handwritten on MAR, starting 2/13/24, instill 1 drop into both eyes QID, scheduled at 7:00am, 11:00am, 3:00pm, and 7:00pm. -3 out of daily 4 doses documented as administered on 2/13/24 and 2/15/24 at 7:00am, 11:00am, and 3:00pm. -2 out of 4 daily doses documented as administered on 2/18/24 and 2/29/24. -3 out of 4 daily doses documented as administered on 2/21/24, 2/23/24, and 2/24/24. -1 out of 4 daily doses documented as administered on 2/30/24 at 7:00am. -Prednisolone Acetate 1%, handwritten on MAR starting 2/13/24, instill 1 drop into both eyes QID, scheduled at 7:00am, 11:00am, 3:00pm, and 7:00pm. -3 out of 4 daily doses documented as administered on 2/13/24, 2/23/24, 2/24/24, and 2/28/24. -2 out of 4 daily doses documented as administered on 2/28/24, and 2/29/24. -1 out of 4 daily doses documented as administered on 2/30/24 at 7:00am. -Trazodone 50mg tab, 1 tab PO Q8H PRN, 14 doses documented as administered from 2/1/24 to 2/25/24. -There was no time documented on the MAR	V 118	This page intentionally left blank	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL011-446	A. BUILDING: _____ B. WING _____	R-C 08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONARCH DBA UMAR-GIVENS	650 BARRETT LANE ASHEVILLE, NC 28803

(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 118	Continued From page 39 when the Trazodone 50mg PRN doses were administered. -A total of at least 40 missed doses of medication according to the documentation on the MAR. March 3/1/24 to 3/31/24: -Loratadine 10mg tab, documented as "D" on 3/19/24 (1 dose missed). -Ofloxacin OP 0.3% eye drops, instill 1 drop into the R eye QID, scheduled at 7:00AM, 12:00pm, 5:00pm, and 9:00pm and discontinued on 3/13/24. -2 out of 4 daily doses documented as administered on 3/12/24 at 5:00pm and 9:00pm. -3 out of 4 daily doses documented as administered on 3/1/24, 3/4/24, 3/5/24, 3/6/24, 3/7/24, 3/8/24, and 3/11/24 at 7:00am, 5:00pm, and 9:00pm. -Prednisolone Acetate 1%, instill 1 drop into R eye scheduled at 7:00am, 12:00pm, 5:00pm, and 9:00pm and discontinued 3/13/24. -2 out of 4 daily doses documented as administered on 3/12/24 at 5:00pm and 9:00pm. -3 out of 4 daily doses documented as administered on 3/1/24, 3/4/24, 3/5/24, 3/6/24, 3/7/24, 3/8/24, and 3/11/24 at 7:00am, 5:00pm, and 9:00pm (at least 20 total doses missed of Ofloxacin and Predinose Acetate). -Additionally, handwritten on the MAR, Ofloxacin OP 0.3% eye drops, starting 3/1/24, instill 1 drop into both eyes QID, scheduled 7:00am, 11:00am, 3:00 pm, and 7:00pm and "D/C" 3/12/24. -Prednisone Acetate 1% handwritten on MAR, starting 3/1/24, instill 1 drop into both eyes QID, scheduled 7:00am, 11:00am, 3:00pm, and 7:00pm and discontinued 3/12/24. -Vitamin B-12 1000mcg, documentation of 9 doses being administered from 3/23/24 to 3/31/24 with no route or start date documented. -Vitamin D3, documented as "D" on 3/19/24.	V 118	This page intentionally left blank	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL011-446	A. BUILDING: _____ B. WING _____	R-C 08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONARCH DBA UMAR-GIVENS	650 BARRETT LANE ASHEVILLE, NC 28803

(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 118	Continued From page 40 -Trazodone 50mg tab, 1 tab PO Q8H PRN, 23 doses documented as administered from 3/1/24 to 3/30/24 with no time documented on MAR when the PRN doses were administered. -47 total doses of medication missed according to the documentation on the MAR. April 4/1/24 to 4/30/24: -Polyethylene Glycol 3350 Powder handwritten on MAR as 17gm(grams) in 8oz (ounces) or more of water/juice daily for constipation, staff initials crossed out on 4/2/24. -No other documentation in April 2024 of administration of Polyethylene Glycol for Client #3. -Risperidone 1mg tab, 1 tab BID (handwritten on MAR), crossed out in ink from 0.5 to 1mg BID. (the MAR did not reflect the date the Risperidone dosage increased to 1mg BID) -Risperidone 1mg tab BID, had staff initials crossed out on the 8:00pm dose on 4/18/24 and no documentation of administration of the 8:00pm dose on 4/19/24. -Risperidone 0.5mg tab was written as "not delivered" on the back of the MAR for 4/18/24. -Risperidone 0.5mg tab BID was not discontinued on the MAR. -Trazodone 100mg tab, QHS was documented as administered from 4/1/24 to 4/21/24. -Trazodone 100mg tab QHS from 4/22/24 to 4/30/24 (8 missed doses) were documented as "D" and on the back, "out of medication." -Trazodone 50mg tab 1 tab Q8H PRN, 13 doses documented as administered from 4/1/24 to 4/29/24. -Trazodone 50mg tab was listed as "out of medication" on back of the MAR on 4/30/24. -A total of at least 39 doses of missed medication according to the documentation on the MAR.	V 118	This page intentionally left blank	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL011-446	A. BUILDING: _____ B. WING _____	R-C 08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONARCH DBA UMAR-GIVENS	650 BARRETT LANE ASHEVILLE, NC 28803

(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 118	Continued From page 41 May 5/1/24 to 5/31/24: -Polyethylene Glycol 3350 Powder, scheduled daily, 10 doses documented as administered from 5/1/24 to 5/31/24 (21 missed doses). -Trazodone 100mg tab, 1 tab QHS, 31 doses documented as "D" on the MAR from 5/1/24-5/31/24 (31 doses missed according to MAR). -Trazodone 50mg tab 1 tab Q8H PRN, 9 doses documented as administered from 5/6/24 to 5/14/24. -Trazodone 50mg tab 1 tab Q8H PRN, 11 doses documented as "D" from 5/15/24 to 5/29/24 -A handwritten sticky note was attached to the MAR, "Out of 100mg tab. Taking 50mg PRN as place holder. Sign PRN 50mg." -5/7/24 to 5/10/24 (Trazodone 50mg) was documented on the back the MAR with "1" circled Trazodone 50mg tab, "out of medication (med), taking 50mg tab PRN as place holder with time noted." -5/11/24 to 5/15/24 (Trazodone 50mg) was documented on the back of the MAR "out of med PRN substitute with time noted." -Unable to determine dosage or frequency of Trazodone administration for Client #3 in May 2024. June 6/1/24 to 6/30/24: -Citalopram 40mg tab, Famotidine 20mg tab, Loratadine 10mg tab, Vitamin D3, and Vitamin B-12; 31 doses documented as administered in June 2024. -Polyethylene Glycol 3350 Powder, scheduled daily at 7:00am on the MAR, 11 doses documented as administered from 6/1/24 to 6/30/24. -Risperidone 1mg tab BID, no documentation of administration for 7:00am and 8:00pm doses on 6/1/24 and 6/2/24, -Trazodone 100mg tab, 1 tab QHS, documented	V 118	This page intentionally left blank	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL011-446	A. BUILDING: _____ B. WING _____	R-C 08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONARCH DBA UMAR-GIVENS	650 BARRETT LANE ASHEVILLE, NC 28803

(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 118	Continued From page 42 as "D" (drug not given) for 30 doses scheduled at 8pm in June 2024. -6/1/24-6/14/24 "Trazodone 100mg. "Doctor hasn't refilled or DC' d, Not Given." Written on back of the MAR. -A total of at least 53 missed doses of medication accoridng to the documentation on the MAR. July 7/1/24-7/18/24: - Polyethylene Glycol 3350 Powder, scheduled daily, 4 doses documented as administered from 7/1/24 to 7/18/24. -Trazodone 100mg tab, documented as "D" on MAR from 7/1/24 to 7/17/24, 0 doses documented as administered. -Trazodone 50mg tab, PRN, still listed on the MAR, 0 doses documented as administered. -A total of 31 missed doses of medication according to the documentation on the MAR. Interview on 7/19/24 with Client #1 revealed: -Limited information as she repeated back what was asked of her. -Takes medication in the morning. -Gets headaches. Interview on 7/18/24 with Staff #1: -Client #1 was admitted to the facility with a med planner. -The facility had since gotten pharmacy dispensed bubble packs for Client #1's medications. - " ...Management (Residential Director/Qualified Professional (RD/QP)) made Client #1's MAR, but it's not based off (physician) orders." - "Still don't have doctor orders" for Client #1. - "She's (Client #1) asked for Tylenol...we don't have it on her MAR or an order to give it." - "I couldn't tell you who it (QP) is...We don't see any of these people."	V 118	This page intentionally left blank	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL011-446	A. BUILDING: _____ B. WING _____	R-C 08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONARCH DBA UMAR-GIVENS	650 BARRETT LANE ASHEVILLE, NC 28803

(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 118	Continued From page 43 -Went to the House Manager (HM) if there is a medication problem. Interview on 7/23/24 with Client #1's Guardian revealed: -Brought copies of prescriptions to the facility when her daughter was admitted (7/15/24). -If Client #1 doesn't get her Singulair (Montelukast) in the morning she (Client #1) would get headaches and allergy symptoms. Interview on 7/18/24 with the HM revealed: -"D" on the MAR stands stand for drugs not given. -Client #1 "complained about headaches on Monday (7/15/24) multiple times." -Could not give Client #1 a Tylenol because the facility doesn't have an over the counter (OTC) order for Client #1. -Client #1 was admitted with a med planner and no prescriptions. -Client #1's mom brought "previous prescriptions (pharmacy labels), but (they) weren't doctor's orders." -Reviewed MARs for signatures. -If there was a missing signature on the MAR for a date, like on 7/5/24 (for Client #2), "it was probably an oversight." -The facility used paper MARs created by the pharmacy. -Client #2's Benefiber Powder may be one of the one of the meds they are out of right now. -Client #2 and #3 had cataract surgery and Client #3 was treated for pink eye. -Client #3's Trazodone 100mg was scheduled to be a nightly medication. She contacted the pharmacy for a refill, but it never got refilled. She spoke with the RD/QP about it, and she said (Trazodone) can't be a PRN medication (Trazodone was listed as PRN and nightly on	V 118	This page intentionally left blank	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL011-446	A. BUILDING: _____ B. WING _____	R-C 08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONARCH DBA UMAR-GIVENS	650 BARRETT LANE ASHEVILLE, NC 28803

(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 118	Continued From page 44 MAR). -Client #3's Trazodone 100mg was still the MAR, "it's (nightly dose) not being given." -Client #3's Trazodone 50mg PRN was still on the MAR but it was no longer being administered. -Admitted there was no further follow up with pharmacist/prescribing provider about Client #3's Trazodone. -Client #3's Polyethylene Glycol was scheduled daily but being administered at the facility as PRN. -There was no oversight of medication other than her. -The RD/QP comes out every few months, "if she (RD/QP) knew the state was coming out, she would visit ...and may check for signatures (on MARs) ..." -The Team Leader/Qualified Professional (TL/QP) had visited the facility once and did not check medications during his visit. Interview on 7/19/24 with the TL/QP revealed: -Responsible for oversight of the facility. -Responsibilities included reviewing medications. -Had been to the facility one time since he was hired in May 2024. -Did not review medications or MARs during his last visit but would be in the future. -Was not aware of medication issues at the facility. Interviews on 7/23/24 and 7/24/24 with the local pharmacist revealed: -Client #1's Cetirizine and Excedrin was processed on 7/22/24 and was delivered to the facility on 7/23/24. "It was not included in the 7/15/24 orders." - "The side effect of not receiving Cetirizine and Excedrin if scheduled to take daily is no symptom control, going to have a headache and going to	V 118	This page intentionally left blank	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL011-446	A. BUILDING: _____ B. WING _____	R-C 08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONARCH DBA UMAR-GIVENS	650 BARRETT LANE ASHEVILLE, NC 28803

(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 118	Continued From page 45 have allergy symptoms." -Ofloxacin OP 0.3% eye drops one drop in right eye QID daily was ordered 2/6/24 and discontinued 3/12/24. Prednisone Acetate 1%, one drop in right eye QID was ordered 2/6/24, no stop date, for a bottle with no refills -Client #3's Trazodone 100mg is scheduled daily, the last fill date was 3/20/24, they (provider) put it in as "99" which is PRN. It wasn't refilled till 7/23/24. -Client #3 also had Trazodone 50mg PRN that was last dispensed on 4/1/24. -Client #3's MiraLAX (Polyethylene Glycol) is scheduled once daily. "Nothing on the pharmacy end that lists it as PRN." -Client #3 had been taking Risperidone since 2021. -Physician order for Risperidone 0.5mg BID since 12/1/23 and discontinued 4/9/24. -Physician ordered for Risperidone 1mg BID since 4/9/24. Interviews on 7/19/24 and 7/26/24 with the RD/QP revealed: -Was acting as the QP during Client #1's admission on 7/15/24 and prior to the new TL/QP being hired in May 2024. -Client #1 was admitted to the facility with physician orders. -The Excedrin order for Client #1 was left in the MAR book for the HM and she (HM) found it a couple days after admission. -OTC physician orders weren't given for Client #1. -Client #3's PRN Trazodone was considered a psychotropic medication, and the Licensee had a policy about staff not giving psychotropic PRNs. -The HM was instructed to work with the physicians to update the orders. -The TL/QP was responsible for medication	V 118	This page intentionally left blank	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL011-446	A. BUILDING: _____ B. WING _____	R-C 08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONARCH DBA UMAR-GIVENS	650 BARRETT LANE ASHEVILLE, NC 28803

(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 118	Continued From page 46 oversight. -They "rely on the QP (TL/QP) to supervise ...if there was a medication issue that I'm aware of then I would follow up more specifically." -Created the MAR for Client #1 and when asked if she hand wrote Montelukast on the MAR, "without being there it's hard to say..." -Not aware of medication issues at the facility. -In regard to who is ultimately responsible for meds, "the QP (TL/QP)." Due to the failure to accurately document medication administration, it could not be determined if clients received their medications as ordered by the physician. Review on 7/31/24 of the plan of protection dated 7/30/24 written by the Vice President of Operations (VP) UMAR Division (Licensee) revealed: "1. All staff assigned to Givens (facility) will be retrained on medication administration. This will ensure that the improper dispensing of medication will not occur. All staff will be retrained by 8/9/24. 2. VP of Operations will also compare the MAR to physician's orders for all residents of Givens (facility). Instructions will be posted related to dispensing meds-right person, right medication, right dosage, right time, right route, right documentation. The review will be completed by 8/2/24. 3. Starting 8/5/24, Residential Manager will observe 3 med passes per week for the next 2 months to ensure staff competency with passing medications. 4. VP of Operations will complete chart review by 8/2/24 to ensure people supported have had a visit with their prescribing physician of psychotropic medications within the past 6-months. If an appointment has not been documented, an appointment will be scheduled with the physician	V 118	This page intentionally left blank	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL011-446	A. BUILDING: _____ B. WING _____	R-C 08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONARCH DBA UMAR-GIVENS	650 BARRETT LANE ASHEVILLE, NC 28803

(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 118	Continued From page 47 as soon as possible. The VP of Operations will also verify the pharmacy has completed a pharmacy review within the past 6 months. If the pharmacy has not completed the review, review will be requested. Describe your plans to make sure the above happens. VP of Operations will ensure implementation for each item noted above with the support of the EVP-COO (Executive Vice President Chief Operating Officer) of the UMAR Division [Licensee]." This deficiency constitutes a recited deficiency. This facility served adult female clients with diagnoses which included the following: Intellectual Disabilities, Cerebral Palsy, Depression, Anxiety, Asthma, Hypertension, Osteoporosis, and Hypothyroidism. Client #1 was admitted on 7/15/24 with a pill planner of unlabeled medications and missing physician orders. There were still no over the counter medications ordered for Client #1 who had chronic headaches for which she required Excedrin. Three clients' MARs (#1, #2, and #3) were not kept current with medication administration. According to the documentation on the MARs, Client #1 missed a total of 6 doses of medication, Client #2 missed a total of 51 doses and Client #3 missed at least 210 doses of medication. The HM and RD/QP handwrote on the MARs with incomplete prescription information and did not start a new line for dosage increases/decreases. Client medications were marked "D" when the facility ran out of medications or when medications were not administered for at least 96 doses for Client #3. Other medications were administered PRN when scheduled daily. Staff initialed they were	V 118	This page intentionally left blank	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL011-446	A. BUILDING: _____ B. WING _____	R-C 08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONARCH DBA UMAR-GIVENS	650 BARRETT LANE ASHEVILLE, NC 28803

(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 118	Continued From page 48 administering medications for 30 days in February 2024 when there were less than 30 days in the month. Client #3 had a history of cataract surgery and treatment for Conjunctivitis. Based on the MAR not being kept current, it was unable to be determined if her eye drops were administered as prescribed. Client #3 was prescribed Trazodone 100mg tablet every night in February 2024 and taking a PRN 50mg dose for psychotic symptoms. The facility ran out of the Trazodone 100mg on 4/22/24. Staff were instructed to use the 50mg PRN tablet as a "place holder" on the MAR in May 2024 with no corresponding documentation that reflected 100mgs was administered to Client #3 as prescribed. It was unable to be determined how much Trazodone was administered to Client #3 during the months of April and May 2024. The facility did not coordinate care by not following up with the prescribing providers. A medication review was not completed for Client #3 despite her being administered psychotropic medication for at least 18 consecutive months. This deficiency constitutes a Type A1 rule violation for serious neglect and must be corrected within 23 days.	V 118	This section intentionally left blank	
V 121	27G .0209 (F) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (f) Medication review: (1) If the client receives psychotropic drugs, the governing body or operator shall be responsible for obtaining a review of each client's drug regimen at least every six months. The review shall be to be performed by a pharmacist or physician. The on-site manager shall assure that	V 121	Pharmacy reviews had been completed every six months by Southern Pharmacy. The manager was not aware of where they were filed. Reviews are now onsite and in EHR for each person supported.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL011-446	A. BUILDING: _____ B. WING _____	R-C 08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONARCH DBA UMAR-GIVENS	650 BARRETT LANE ASHEVILLE, NC 28803

(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 121	Continued From page 49 the client's physician is informed of the results of the review when medical intervention is indicated. (2) The findings of the drug regimen review shall be recorded in the client record along with corrective action, if applicable. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to obtain a pharmacist or physicians medication review at least every six months for all clients receiving psychotropic drugs for 1 of 4 audited clients (#3). The findings are: Review on 7/18/24 of Client #3's record revealed: Date of Admission: 8/1/97. Diagnoses: Mild Intellectual Developmental Disability, Hypertension, Hyperlipidemia, Depression, Anxiety, Osteoporosis, and Other Seasonal Allergies. -No documentation of a medication review for Client #3. Review on 7/18/24 and 7/25/24 of Client #3's MAR dated 2/1/24 to 7/18/24, revealed: -Risperidone 0.5mg/1milligram (mg) (psychosis), take 1 tablet (tab), by mouth (PO) twice a day (BID). -Trazodone 100mg tab, (sedation/antidepressant), take 1 tab PO at bedtime (QHS). -Trazodone 50mg tab, (sedation/antidepressant) take 1 tab, as needed (PRN) every 8 hours (Q8H). Interview on 7/24/24 with the House Manager (HM) revealed:	V 121	Residential Director or QP designee will review MARs and Signed Physician's Orders monthly, and upon any new orders for accuracy and completion. Implementation: 8/30/24 Ongoing	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL011-446	A. BUILDING: _____ B. WING _____	R-C 08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONARCH DBA UMAR-GIVENS	650 BARRETT LANE ASHEVILLE, NC 28803

(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 121	Continued From page 50 -Client #3 had been taking Risperidone for a year and a half. - " ...Don't have any med (medication) reviews on site ... would have been before UMAR (Former Licensee) was absorbed by MONARCH (Licensee)." Interviews on 7/24/24 and 7/26/24 with the local pharmacist revealed: -Risperidone had been ordered for Client #3 for "a long time ...since 2021." -Trazodone 100mg, 1 tab QHS, had an order date of 12/22/23. Interview on 7/19/24 with the Team Leader/Qualified Professional (TL/QP) revealed: -Had been to the facility one time since he was hired in May 2024. -Responsibilities included medication oversight. -Had not reviewed medications at the facility yet. Interview on 7/26/24 with the Residential Director/Qualified Professional (RD/QP) revealed: -There should be medication reviews in the client records. -Unaware there was a missing medication review. This deficiency constitutes a recited deficiency. This deficiency is cross referenced into 10A NCAC 27G .0209 Medication Requirements for a Type A1 rule violation and must be corrected within 23 days.	V 121	This page intentionally left blank	
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)	V 290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL011-446	A. BUILDING: _____ B. WING _____	R-C 08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONARCH DBA UMAR-GIVENS	650 BARRETT LANE ASHEVILLE, NC 28803

(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	Continued From page 51 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 present during sleeping hours if specified by the emergency back-up procedures determined by the governing body; or (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. (d) In facilities which serve clients whose primary diagnosis is substance abuse dependency: (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 (2) the services of a certified substance	V 290	Staff pattern was re-evaluated by Residential Director and VP of Operations on 7/24/2024. To meet the needs of new admissions and all people supported at Givens, two staff will be on shift at all times. During the hours of 10pm-6am, one of those staff will be asleep onsite and the other awake. The site will have onsite QP support weekly by Residential Director or designated QP to provide ongoing support and supervision. Additionally, Residential Director and VP of Operations will complete weekly review of staff schedules to assure appropriate staffing. Implementation: 8/30/24 Ongoing	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL011-446	A. BUILDING: _____ B. WING _____	R-C 08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONARCH DBA UMAR-GIVENS	650 BARRETT LANE ASHEVILLE, NC 28803

(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	Continued From page 52 abuse counselor shall be available on an as-needed basis for each client. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure staffing to meet the individualized needs of the clients served. The findings are: Review on 7/18/24 and 7/23/24 of Client #1's record revealed: -Admission Date: 7/15/24. -Diagnoses: Anxiety Disorder, Unspecified; Hypothyroidism; Cerebral Palsy; Malignant Neoplasm of pituitary gland; Vitamin D Deficiency; Unspecified Asthma (uncomplicated); Moderate Intellectual Developmental Disability (IDD); Dorsalgia, Unspecified; Hypopituitarism; and Other Seasonal Allergic Rhinitis. Refer to Tag V108 for Client #1's Health Risk Assessment dated 4/8/24, Individualized Support Plan dated 7/1/24, and the facility's Admission Assessment dated 7/23/24 identifying Client #1's needs. Review on 7/26/24 of an email received from Client #1's Hoyer lift company consumer support team revealed: -"Most lifts typically require the assistance of two or more caregivers, depending on the patient's condition." Review on 7/25/24 of Client #1's Hoyer lift operating manual instructions revealed: - Page 16, One Piece Sling Continued (Cont.): -"With both attendants holding the patient,	V 290	This page intentionally left blank	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL011-446	A. BUILDING: _____ B. WING _____	R-C 08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONARCH DBA UMAR-GIVENS	650 BARRETT LANE ASHEVILLE, NC 28803

(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	Continued From page 53 push the folded sling under the patient without rolling him/her over." -"NOTE: [Equipment Company] recommends that two (2) attendants (One [1] on each side of the bed) be used when positioning the patient in a sling." -"With an attendant on each side of the bed and up against the mattress, the attendant on the left-hand side of the bed will position his/her RIGHT-HAND on the elevated KNEE and his/ her LEFT-HAND under the patient's RIGHT SHOULDER, slowly push on the knee and assist with a slight lift of the shoulder and the patient will easily roll onto their side." -Page 27, Transferring to a Wheelchair: -"NOTE: [Equipment Company] recommends that two (2) attendants be used when transferring a patient to a wheelchair." -"With one (1) attendant behind the chair and the other operating the patient lift, the attendant behind the chair will pull back on the handle or sides of the sling to place the patient into the back of the chair. This will maintain a good center of balance and prevent the chair from tipping forward." Review on 7/26/24 of Client #1's Hoyer lift patient lift safety guide revealed: -"Most lifts require two or more caregivers to safely operate lift and handle patient." -"When selecting a lift for home use, ensure you have the required number of caregivers needed to operate the lift." Review on 7/18/24 of the facility's staffing schedule posted on the door of office revealed: -On 7/15/24, one staff was on shift with the House Manager (HM) from 6am-4pm and Staff #4 worked alone from 9pm-12am. -On 7/16/24, Staff #3 worked alone from	V 290	This page intentionally left blank	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL011-446	A. BUILDING: _____ B. WING _____	R-C 08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONARCH DBA UMAR-GIVENS	650 BARRETT LANE ASHEVILLE, NC 28803

(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	Continued From page 54 12am-6am, one staff was on shift with the HM from 6am-11am, and Staff #4 worked alone from 9pm-12am. -On 7/17/24 Staff #3 worked alone from 12am-8am, one staff was on shift with the HM from 6am-4pm, and Staff #4 worked alone from 9pm-12am. - On 7/18/24 Staff #3 worked alone from 12am-8am, one staff was on shift with the HM from 6am-4pm, and Staff #4 worked alone from 9pm-12am. Interviews on 7/18/24 and 7/24/24 with Staff #1 revealed: -Got "called in to help" on the day of admission for Client #1, arrived around 12:30pm. -"...we don't have enough staff...it takes three of us (staff) to transfer her (Client #1)...[Residential Director/Qualified Professional (RD/QP)] just gives corporate response...we are gonna post the job...we've had jobs posted for over a year." -"When I got there (7/15/24)...staff just talking amongst (other) staff about what to do (about Client #1's needs and level of assistance)...basically just us trying to figure it out on our own." Interview on 7/24/24 with Staff #3 revealed: -Was on shift by himself from 7/16/24-7/18/24,12am-6am. -"Worked by myself always...was manageable until [Client #1] was admitted." -Client #1 needs "...total assistance with everything...not much she can do on her own." -"Even with 2 people (staff) it is still difficult with how much care [Client #1] needs...hard to take care of the other ladies (clients)." -"I addressed concerns about the difficulty with transfers...with my manager (HM) about [Client #1], she (HM) told [RD/QP] and [RD/QP] said that	V 290	This page intentionally left blank	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL011-446	A. BUILDING: _____ B. WING _____	R-C 08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONARCH DBA UMAR-GIVENS	650 BARRETT LANE ASHEVILLE, NC 28803

(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	Continued From page 55 staff can handle it...staff will get used to it." Interview on 7/24/24 with Staff #4 revealed: -"...by myself (on shift) from 9pm to 12am, 7/15/24-7/18/24." -"Usually work alone...can't do the Hoyer lift and transfer [Client #1] alone..." Interview on 7/19/24 with the HM revealed: -"Only one staff scheduled that day (7/15/24)...would have been [Staff #4] working at 4pm...1 person (staff) every shift (along with herself)...currently need 2 staff to transfer [Client #1] and helping with bathroom and showering." -"I started coming in at 6am to help get her (Client #1) up and ready for the morning...has a wet pull up every morning...changing the pull ups, bed pads, socks, braces, pants then shoes...roll her on the blanket that gets her on the Hoyer...once got her lifted out of bed then transfer to wheelchair...then change bra and shirt." -"...talked to [RD/QP] in person the day of her (Client #1's) admission (7/15/24) and following day (7/16/24 about transfer and staffing concerns)...(RD/QP) response was we're working on hiring staff..." Interview on 7/19/24 with Team Leader/Qualified Professional (TL/QP) revealed: -"Came to the facility once..." since hired on 5/1/24. -"No concerns" with not having enough staff working at the facility to care for the clients' needs. -Client #1 "needs round the clock care from the staff...assist him (her) with being more mobile through staff assistance." - Knew that it took multiple staff to transfer Client #1 out of the bed. -"...should be 2 staff at night."	V 290	This page intentionally left blank	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL011-446	A. BUILDING: _____ B. WING _____	R-C 08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONARCH DBA UMAR-GIVENS	650 BARRETT LANE ASHEVILLE, NC 28803

(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	Continued From page 56 -Was aware that only 1 staff was working at night (since Client #1 was admitted 7/15/24), "...we are hiring and trying to get more staff in the home (facility)." Interview on 8/5/24 with Client #1's Occupational Therapist revealed: -Visited the facility on 7/31/24 and did a full evaluation with Client #1. -"Hoyer lifts should always have 2 staff to transfer..." Interview on 7/23/24 with the RD/QP revealed: -Believed the facility was adequately staffed now after "...bringing in that second person...we're going to keep 2 people on 24 hours a day..." because there was not that level of coverage in the past when Client #1 was first admitted to the facility. -"...until recently, had one staff on shift in the evening." -"...Need a 2nd person to assist (with transfers)..." This deficiency is cross referenced into 10A NCAC 27G .0203 Competencies of Qualified Professionals and Associate Professionals (V109) for a Type A1 rule violation and must be corrected within 23 days.	V 290	This section intentionally left blank	
V 291	27G .5603 Supervised Living - Operations 10A NCAC 27G .5603 OPERATIONS (a) Capacity. A facility shall serve no more than six clients when the clients have mental illness or developmental disabilities. Any facility licensed on June 15, 2001, and providing services to more than six clients at that time, may continue to provide services at no more than the facility's licensed capacity.	V 291	Residential Director will schedule a team meeting with clinical treatment team members (internal and external providers, etc.). by 9/13/2024	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL011-446	A. BUILDING: _____ B. WING _____	R-C 08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONARCH DBA UMAR-GIVENS	650 BARRETT LANE ASHEVILLE, NC 28803

(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 291	Continued From page 57 (b) Service Coordination. Coordination shall be maintained between the facility operator and the qualified professionals who are responsible for treatment/habilitation or case management. (c) Participation of the Family or Legally Responsible Person. Each client shall be provided the opportunity to maintain an ongoing relationship with her or his family through such means as visits to the facility and visits outside the facility. Reports shall be submitted at least annually to the parent of a minor resident, or the legally responsible person of an adult resident. Reports may be in writing or take the form of a conference and shall focus on the client's progress toward meeting individual goals. (d) Program Activities. Each client shall have 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 and interview, the facility failed to ensure service coordination was maintained with other professionals responsible for treatment for 1 of 4 audited clients (#3). Review on 7/18/24 of Client #3's record revealed: Date of Admission: 8/1/97. Diagnoses: Mild Intellectual Developmental Disability, Hypertension, Hyperlipidemia, Depression, Anxiety, Osteoporosis, and Seasonal Allergies. Review on 7/18/24 and 7/25/24 of Client #3's	V 291	Staff will be in serviced on follow-up steps to a Physicians or Provider appointments by Director of Nursing and Residential Director. The importance of service coordination will be discussed to include communication with guardians, day programs, all applicable treatment team members. Implementation: 8/30/24 Ongoing	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL011-446	A. BUILDING: _____ B. WING _____	R-C 08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONARCH DBA UMAR-GIVENS	650 BARRETT LANE ASHEVILLE, NC 28803

(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 291	Continued From page 58 MARS from 2/1/24 to 7/18/24 revealed: -Trazodone 100 milligram (mg) 1 tablet (tab) (sedation/antidepressant), by mouth (PO), at bedtime (QHS) scheduled daily. -Trazodone 50mg tab, 1 tab PO, as needed (PRN), every 8 hours (Q8H) for agitation. -Trazodone 100mg tab, QHS was documented as administered from 2/1/24 to 4/21/24. -Trazodone 50mg tab, PRN documented 59 doses as administered from 2/1/24 to 5/14/24. -Trazodone 100mg tab was last administered on 4/21/24. -Trazodone 50mg tab was last administered on 5/14/24. Interviews on 7/18/24 and 7/19/24 with the House Manager (HM) revealed: -Trazodone 100mg tab, is still scheduled on the MAR but was not being filled currently. -Client #3 ran out of the 100mg in April (2024) and contacted the pharmacy but they (pharmacy) never sent the 100mg. -The pharmacy normally sent enough medication to get through the cycle (100mg was a cycled medication (med)) and they didn't. - "With Client #3 having the 100mg and 50mg as PRN ... (the 100mg wasn't sent) the pharmacist told her to give her (Client #3) 2 of the 50mgs until the 100mg could be re-filled ...and it never was." -Pharmacist told the facility that the 100mg refill was listed as PRN. -Spoke with her supervisor Residential Director/Qualified Professional (RD/QP) about it and was advised that Trazodone was a psychotropic medication and cannot be a PRN, "but it's still on the MAR." -Client #3 was no longer seeing the doctor that prescribed the 100mg QHS and was with a new doctor at the day program.	V 291	This page intentionally left blank	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL011-446	A. BUILDING: _____ B. WING _____	R-C 08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONARCH DBA UMAR-GIVENS	650 BARRETT LANE ASHEVILLE, NC 28803

(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 291	Continued From page 59 -Client #3 stopped attending the day program in the middle of May 2024. -Client #3 just recently started going back to the day program. -No follow up with the pharmacy or coordination of care with the prescribing provider after this. -When asked who was prescribing Client #3's meds right now, "I don't know." -Client #3's Polyethylene Glycol 3350 Powder was changed to PRN from the day program doctor. - "This was months ago (that the prescription was changed) ...it's listed as scheduled but being treated as PRN. -No follow up to ensure this was corrected. Interview on 7/19/24 with the Team Leader/Qualified Professional (TL/QP) -Not aware of medication issues at the facility. Interview on 7/23/24 and 7/26/24 with the pharmacist revealed: -Client #3's Trazodone 100mg tab was last dispensed on 3/20/24. -The last physician order for Trazodone 100mg QHS was 3/20/24. -The refills on the last physician order for Trazodone 100mg QHS on 3/20/24 listed the refills as "99" which is PRN. -Last physician order for Trazodone 50mg tab PRN was 3/20/24. -Trazodone 50mg tab PRN was last dispensed on 4/1/24. -There is a gap in Trazodone 100mg getting dispensed (filled) from 3/20/24 to 7/23/24. -Client #3's Polyethylene Glycol (MiraLAX) is scheduled once daily. "Nothing on the pharmacy end that lists it as PRN." -Last physician order for Polyethylene Glycol daily is 7/1/24.	V 291	This page intentionally left blank	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL011-446	A. BUILDING: _____ B. WING _____	R-C 08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONARCH DBA UMAR-GIVENS	650 BARRETT LANE ASHEVILLE, NC 28803

(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 291	Continued From page 60 Interview on 7/26/24 with the RD/QP revealed: -There had been a lapse in QPs for the facility. - "Came on board in my role as RD/QP on 12/27/23 ...and until TL/QP was hired recently (May 2024), there was not a QP there." -Supervised the TL/QP and had been helping with QP duties at that home. -Client #3's PRN Trazodone was considered a psychotropic medication, and the Licensee has a policy about staff not giving psychotropic PRNs. -The HM was instructed to work with the physicians to update the orders. -The QP (QP/TL) was responsible for medication oversight. This deficiency is cross referenced into 10A NCAC 27G .0209 Medication Requirements for a Type A1 rule violation.	V 291	This section intentionally left blank	
V 540	27F .0103 Client Rights - Health, Hygiene And Grooming 10A NCAC 27F .0103 HEALTH, HYGIENE AND GROOMING (a) Each client shall be assured the right to dignity, privacy and humane care in the provision of personal health, hygiene and grooming care. Such rights shall include, but need not be limited to the: (1) opportunity for a shower or tub bath daily, or more often as needed; (2) opportunity to shave at least daily; (3) opportunity to obtain the services of a barber or a beautician; and (4) provision of linens and towels, toilet paper and soap for each client and other individual personal hygiene articles for each indigent client. Such other articles include but are	V 540	VP Operations, in consultation with OT, created task analysis for 2-person transfer. Implementation: 8/30/24 Ongoing Staff were in-serviced on task analysis on 08/20/2024 and utilized 2 person transfer until 9/3/2024 Grab bar has been installed on right side of toilet on 9/3/2024.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL011-446	A. BUILDING: _____ B. WING _____	R-C 08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONARCH DBA UMAR-GIVENS	650 BARRETT LANE ASHEVILLE, NC 28803

(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 540	Continued From page 61 not limited to toothpaste, toothbrush, sanitary napkins, tampons, shaving cream and shaving utensil. (b) Bathtubs or showers and toilets which ensure individual privacy shall be available. (c) Adequate toilets, lavatory and bath facilities equipped for use by a client with a mobility impairment shall be available. This Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure an adequate toilet for use by a client with a mobility impairment affecting 1 of 4 audited clients (#1). The findings are: Review on 7/18/24 and 7/20/24 of Client #1's record revealed: -Admission Date: 7/15/24. -Diagnoses: Anxiety Disorder, Unspecified; Hypothyroidism; Cerebral Palsy; Malignant Neoplasm of pituitary gland; Vitamin D Deficiency; Unspecified Asthma (uncomplicated); Moderate Intellectual Developmental Disability; Dorsalgia, Unspecified; Hypopituitarism; and Other Seasonal Allergic Rhinitis. -Health Risk Assessment completed by Care Coordinator (CC) dated 4/8/24: -"[Client #1] requires full staff support in the bathroom." -"Does the member need home modification? Yes...bathroom...completely modified to be accessible for her needs." Interview on 7/19/24 with Client #1 revealed: -Limited information as she repeated back what was asked of her and also "forgot" what she was	V 540	This page intentionally left blank	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL011-446	A. BUILDING: _____ B. WING _____	R-C 08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONARCH DBA UMAR-GIVENS	650 BARRETT LANE ASHEVILLE, NC 28803

(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 540	Continued From page 62 discussing. -"Staff help me use the bathroom..." Interview on 7/24/24 with Client #1's Guardian revealed: -Toured the facility on 4/30/24 with Client #1 and Client #1's brother. -Addressed concerns with the Residential Director/Qualified Professional (RD/QP) and the House Manager (HM) on 4/30/24 that the "...bathroom was different than how it was at home...facility toilet handrail was on the left." -"The way the facility's bathroom was set up was a concern since it was different than how it was at home..." -Was concerned because in Client #1's facility bathroom, the "...handrail was on the left...she (Client #1) needs one on the right." -Client #1's "left hand is not useable...if she has one (grab bar) on the right side, she can get a hold of it and turn herself and position herself..." Interview on 7/26/24 Client #1's Care Coordinator revealed: -Client #1, Client #1's Guardian, Client #1's brother and herself toured the facility on 4/30/24. -During the tour of the facility, Client #1's Guardian told the RD/QP and the HM that the way the toilet was set up in the facility was "opposite to what [Client #1] had set up at home..." Observation on 7/18/24 at 11:32AM of Client #1's bathroom revealed: -Upon entering the bathroom, the toilet was positioned to the left in the corner of the room with a metal grab bar mounted on the wall on the left side of the toilet. -A pillow that had been placed inside a thin blue translucent trash bag rested on the toilet seat up	V 540	This page intentionally left blank	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL011-446	A. BUILDING: _____ B. WING _____	R-C 08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONARCH DBA UMAR-GIVENS	650 BARRETT LANE ASHEVILLE, NC 28803

(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 540	Continued From page 63 against the tank. -Two pieces of cardboard were folded behind the toilet tank up against the wall. -The toilet seat was loose to the touch and off-centered slightly to the left. -A portable commode was positioned to the right of the toilet with handlebars on each side. -The portable commode was not secured to the floor and was wobbly to the touch. Review on 8/7/24 of an Occupational Therapy (OT) Evaluation completed by Client #1's OT dated 7/31/24 revealed: -Regarding the current toileting area, "...OT educated that this setup is very unsafe for [Client #1]. The right sided bedside commode (BSC) is unstable and can move during transfers. She (Client #1) does not have functional use of her left upper extremity (LUE) and cannot use the left sided grab bar. OT is recommending a new toilet system to increase independence with her activities of daily living (ADLs) and keep her safe during bathroom transfers." -"She (Client #1) has fallen in the past on the toilet." Interviews on 7/18/24 and 7/24/24 with Staff #1 revealed: -"[Client #1's] bathroom toilet is up against the wall and handrails are against left side." -"[Client #1] has left sided hemiplegia." -For Client #1's toileting routine, "...2 people wheel her into the bathroom...2 people pick her up...shimmy her to toilet...one person pulls her (Client #1) pants down...one person holds her (Client #1) weight on their back." -"...(staff) having to hold her back to sit her down (on the toilet)...flops on to toilet...one person (staff) holds her in front and other person (staff)	V 540	This page intentionally left blank	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL011-446	A. BUILDING: _____ B. WING _____	R-C 08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONARCH DBA UMAR-GIVENS	650 BARRETT LANE ASHEVILLE, NC 28803

(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 540	Continued From page 64 holds her on her side." -"Bathroom isn't oriented the right way...not a great situation." -"We (staff) stuck cardboard boxes behind tank so it's not loose." -The "toilet tank shifts and gives causing her to slide off...seat is loose and starts to shift and now after multiple times the seat is loose and shifts more." -Client #1's "strong side is the right side...there was nothing on the right side of the toilet...staff were on the right side of the toilet helping her stabilize while (other) staff were also on the left holding her upright." -When concerns were brought up to the RD/QP that the toilet was unsafe after Client #1's first bathroom transfer on 7/15/24, her response was "...well she'll just have to get a referral to OT" and the RD/QP's solution was to "...use a bedside toilet from a former client" for Client #1 to grab for stabilization on the right side of the toilet. Interviews on 7/18/24 and 7/24/24 with Staff #2 revealed: -Was on shift when Client #1 was admitted, "...helped move her (Client #1) in." -Participated in Client #1's first transfer from her wheelchair to the toilet on 7/15/24. -"I worked with wheelchair bound clients before...everyone else (staff) didn't have training." -Client #1's Guardian and the HM demonstrated transferring Client #1 from her wheelchair to the toilet when Client #1 was admitted to the facility. -Client #1's Guardian "...was talking staff through what to do for [Client #1]." -After Client #1's Guardian and the HM demonstrated a toilet transfer, "...we (staff) had to figure out what was best for how staff can assist her (Client #1)."	V 540	This page intentionally left blank	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL011-446	A. BUILDING: _____ B. WING _____	R-C 08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONARCH DBA UMAR-GIVENS	650 BARRETT LANE ASHEVILLE, NC 28803

(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 540	Continued From page 65 Interview on 7/24/24 with Staff #4 revealed: -Arrived on shift at 4pm the day Client #1 was admitted. -"Staff #2 helped me get [Client #1] on the toilet on 7/15/24." -"Knew 2 months ago (prior to Client #1's admission) that someone was coming that was in a wheelchair and needed assistance using the bathroom, but the information was very limited." -"...I thought for sure someone would come by and see if the facility would support [Client #1]." -On the day of Client #1's admission, Client #1's Guardian brought a "toilet seat we couldn't use because there was not enough space for it...it was too high for the toilet." -When I helped Client #1 use the bathroom, "...I crouched down and helped her (Client #1) stabilize...using me to stabilize with her right arm." -"There was nothing holding her up on the toilet." -"...we (staff) made makeshift adaptive equipment...we took a pillow, put a garbage bag over it to make it waterproof, and put it behind her while she is on the toilet to help her sit up as straight as possible." -"...we put cardboard behind toilet tank to keep it from sliding while she was on it." Interviews on 7/19/24, 7/25/24, and 8/6/24 with the HM revealed: -Was at the facility with Client #1 during admission on 7/15/24. -During Client #1's first transfer from her chair to the toilet, "...[Client #1's Guardian] was trying to do hands on...mostly struggling, talking us (staff) through...[Client #1] was freaking out screaming...then [RD/QP] came around the corner to see what was going on...[Staff #2] got [Client #1] out of the (wheel) chair...then I was being used as support on her right side to help	V 540	This page intentionally left blank	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL011-446	A. BUILDING: _____ B. WING _____	R-C 08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONARCH DBA UMAR-GIVENS	650 BARRETT LANE ASHEVILLE, NC 28803

(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 540	Continued From page 66 stabilize...(staff) have to wipe her...prompt her to squat and staff wipes her." -"...staff are holding [Client #1] on the toilet and [Client #1] is holding the bedside commode." -Staffs' concerns addressed in person with the RD/QP on 7/15/24 and 7/16/24 were "...no right-side grab bar for her (client #1)...when she would sit back on the toilet the tank would shift back and hit wall...(Client #1) can't sit up properly so she leans back too far." -The RD/QP responded to the concerns regarding no right-side grab bar on the toilet for Client #1 to use was to "...use the bedside commode from a previous client on the right side of the toilet." -The RD/QP responded to the concerns regarding the toilet tank shifting back and hitting wall when Client #1 sat up against it was for staff to "...put a maintenance order in to get the toilet tank steady so it doesn't fall back." -"...maintenance staff said there is no good way to stop the toilet tank from leaning back." Interview on 7/19/24 with the Team Leader/Qualified Professional (TL/QP) revealed: -Client #1 "...needs round the clock care from the staff...assist him (her) with being more mobile through staff assistance." -Had "no concerns" with the layout of the facility in relation to Client #1's care. Interview on 8/5/24 with Client #1's OT revealed: -Visited the facility on 7/31/24 and did a full evaluation with Client #1. -Had concerns about the "...bathroom and toilet." -The way in which facility staff transferred Client #1 was "...super unsafe...recommended an order for a new toilet system...cannot have any equipment moving while doing transfers." -"[Client #1] has left side weakness and limited	V 540	This page intentionally left blank	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL011-446	A. BUILDING: _____ B. WING _____	R-C 08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONARCH DBA UMAR-GIVENS	650 BARRETT LANE ASHEVILLE, NC 28803

(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 540	Continued From page 67 range of motion...they have a bed side commode on the right (of the toilet) that is not secured...can't have anyone transferring while they are holding on to a moveable toilet (commode)." -"...was going to come back to observe transfers and ensure staff were doing it safely because the current set up was not safe." Interviews on 7/23/24 and 7/26/24 with the RD/QP revealed: -Was present when Client #1 toured the facility on 4/30/24. -Was at the facility with Client #1 during admission on 7/15/24. - The TL/QP and the HM was responsible to ensure adaptive equipment was in the facility. -Staff expressed concerns to her about how the bathroom was set up for Client #1. -Prior to the OT evaluation completed on 7/31/24, she identified a temporary solution for Client #1 to use...a former client's "...3 in 1 (portable) commode with something for her to hold on to with her good hand." Review on 8/7/24 of the Plan of Protection (POP) dated 8/7/24 written by the Vice President (VP) of Operations of the UMAR Division (Licensee) revealed: -"What immediate action will the facility take to ensure the safety of the consumers in your care? 1. OT evaluation occurred on 7/31/2024. Written report not yet received. Residential Manager requested a copy of the written recommendations today, 8/6/2024. 2. Based on recommendations, equipment will be ordered by Residential Manager to support transfers and toileting. 3. Re-training for the Hoyer lift is occurring with all staff as indicated in previous POP. Observations will continue to verify competency.	V 540	This page intentionally left blank	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL011-446	A. BUILDING: _____ B. WING _____	R-C 08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONARCH DBA UMAR-GIVENS	650 BARRETT LANE ASHEVILLE, NC 28803

(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 540	Continued From page 68 Describe your plans to make sure the above happens. 1. At minimum, weekly onsite visits by Residential Team Leader (TL/QP) or designated team member will monitor progress. 2. VP of Operations will ensure implementation for each item noted above with the support of the EVP-COO (Executive Vice President-Chief Operating Officer) of the UMAR Division." Review on 8/7/24 of the amended Plan of Protection dated 8/7/24 written by the Vice President of Operations of the UMAR Division revealed: -"What immediate action will the facility take to ensure the safety of the consumers in your care? 4. Until the recommended equipment is in place, 2 staff will assist [Client #1] with transferring to the toilet and at least 1 staff will remain with her in the restroom while she is toileting to ensure her safety." Client #1's diagnoses included, but were not limited to, Cerebral Palsy, Moderate IDD, and Dorsalgia. Client #1 had no functional use of her left upper extremity. On 4/30/24, Client #1 and her family toured the facility prior to Client #1's admission. Client #1's Guardian expressed concerns that the only grab bar in the facility's bathroom was located on the left-hand side of the toilet and that modifications would be needed to support Client #1's needs. No modifications were made to the facility bathroom from 4/30/24 to Client #1's admission on 7/15/24. Facility staff, with minimal support and direction from management, created make-shift adjustments to the facility's bathroom which included: placement of a bedroom pillow wrapped in a garbage bag placed at the back of the toilet seat to support Client #1's back, pieces of cardboard between the toilet tank and the bathroom wall to prevent	V 540	This page intentionally left blank	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL011-446	A. BUILDING: _____ B. WING _____	R-C 08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONARCH DBA UMAR-GIVENS	650 BARRETT LANE ASHEVILLE, NC 28803

(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 540	Continued From page 69 movement during transfers and use of the toilet; and an unsecured portable commode on the right-hand side of the toilet for Client #1 to use for stability. Staffs' concerns regarding Client #1's safety presented to the RD/QP were met with minimal resolution. After 16 days at the facility, an OT evaluation was completed. The OT determined the facility's current bathroom environment was unsafe based upon Client #1's needs. This deficiency constitutes a Type A2 rule violation for substantial risk of serious harm and must be corrected within 23 days.	V 540	This page intentionally left blank	