Division of Health Service Regulation

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			B. WING		40/00/2024	
		MHL0411266	B. WING	B. WING 10/09/2024		
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ODRESS, CITY, STA	TE, ZIP CODE		
MONARCH DBA UMAR-ERVIN  1400 SPRINGTREE COURT  HIGH POINT, NC 27265						
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
V 000	INITIAL COMMENTS		V 000			
	2024. A deficiency wa This facility is licensed category: 10A NCAC Living for Adults with	d for the following service 27G .5600C Supervised Developmental Disabilities.  d for 6 and has a current ey sample consisted of				
V 112	PLAN  (c) The plan shall be assessment, and in p legally responsible per of admission for clien receive services beyond (d) The plan shall incompose the projected date of achieved by provision projected date of achieved by a staff responsible;  (3) staff responsible;  (4) a schedule for reannually in consultation responsible person of the projected date of achieved by the projected date of achieved by a schedule for reannually in consultation responsible person of the projected date of achievement (b) written consent of the projected date of th	developed based on the artnership with the client or erson or both, within 30 days ts who are expected to and 30 days. clude:  that are anticipated to be a of the service and a evement;  view of the plan at least on with the client or legally both; on or assessment of	V 112			
	assessment, and in p legally responsible per of admission for client receive services beyon (d) The plan shall incomplete (e) client outcome(s) achieved by provision projected date of achieved by provision projected date of achieved (e) strategies; (a) staff responsible for reannually in consultation responsible person of (5) basis for evaluation outcome achievement (6) written consent of responsible party, or a provider stating why services admission of the consent	artnership with the client or erson or both, within 30 days ts who are expected to and 30 days. Blude:  I that are anticipated to be a of the service and a levement;  View of the plan at least on with the client or legally both; on or assessment of t; and or agreement by the client or a written statement by the				

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

(X6) DATE TITLE

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED		
			7.1. 56.125.1.16.				
		MHL0411266	B. WING		10	/09/2024	
NAME OF P	ROVIDER OR SUPPLIER	STREETA	DDRESS, CITY, STATE	, ZIP CODE			
MONADO	LDDA LIMAD EDVIN	1400 SPI	RINGTREE COURT				
MONARCI	H DBA UMAR-ERVIN	HIGH PC	INT, NC 27265				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
V 112	Continued From page	1	V 112				
	or service plan at leas	ew and interviews, the the treatment/habilitation and annually with the client or rson for 1 of 3 audited					
	Memory Loss, Comple Ear, Asthma, and Hist -Age 47 -An assessment dated very nice, easy to get very complimentary, vertain routine, but if yexpects you to adhere walks, ride his bike, gevents, oriented at all continent with bowel assistance in washing dresses self, ties shown assistance with care of items, cooking simple community mobility-deattention to his health and frustration, is gen patient with situations	f 6/5/15 cellectual Disability and ete Hearing Loss in Right tory of Bowel Infections.  d 4/27/15 noted "easy going, along with, well-mannered, very shy, does not have a you give him a time, he eto the time, likes to go for oing out to eat, family times, ambulatory, and bladder, without hair, bathing, combs hair, es and feeds self, needs of clothing, care of personal meals, shopping and					

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STATE FORM 6899 F6U611 If continuation sheet 2 of 5

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DIVISION	i Health Service Negu	ialion				
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COMPLETED		
			B. WING		1	
		MHL0411266	B. WING	<del></del>	10/0	9/2024
NAME OF PR	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
			NGTREE COU			
MONARCH DBA UMAR-ERVIN HIGH POINT, NC 27265						
	OUR MAR DV OT		<del>'</del>			
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
PREFIX TAG		LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPI		DATE
				DEFICIENCY)		
V 440	0 " 15	0	V 440			
V 112	Continued From page	2	V 112			
	his demeanor or routi	ne, has a high tolerance for				
	pain, takes anti-nause	ea medication and when				
		ch problems, sometimes				
		avoid nausea, has cellulitis				
		nt swelling around ankles				
	-	ental potassium tablet,				
		shed applesauce with oral				
	medications, has part					
		, yoga via Zoom and likes a				
		changes can cause him				
	· ·	•				
		for breakfast and get ready				
	· ·	er. This had become an				
	issue because most o					
	· ·	n duty or morning cleaning,				
		him and needs a goal to				
		ponsibilities, can carry small				
		p to \$30 at a time, may not				
	stay alone in the com	· · · · · · · · · · · · · · · · · · ·				
		l Olympic events or at				
		at home from the hours of 6				
	am to 9 pm."					
	•	t plan dated 7/31/23 noted				
		prompts, will start and				
		ie is asked so others are not				
	•	00% accuracy, will promptly				
		om the dryer, will promptly				
	complete a chore that	t has someone waiting on				
		neatly care for his room on a				
	regular basis not less	than once a week, will				
	neatly fold and place	laundry in drawers, will				
		vear weather and season				
		ff and will gather out of				
		lace them in storage to				
		n and practice emergency				
		ently each week 100% of				
		call 911 in an emergency,				
		roup home in the event of				
		pasic emergency procedures				
		the correct emergency				
	and will learn to state	the contect emergency				

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protocol when presented with a practice scenario,

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND FLAN	OF CORRECTION	IDENTIFICATION NOWIBER.	A. BUILDING:		COMPLE	
		MHL0411266	B. WING		10/09	9/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
MONARC	H DBA UMAR-ERVIN	1400 SPRII	NGTREE COU	RT		
MONANO						
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	D BE	(X5) COMPLETE DATE
V 112	and organize his persisthe time, will gather heremove papers, wrap receptacles to be throwipe furniture with dupaper towels to clean sweep under the bedunderneath of the very day will ride his verbal prompt, and with the clock of the constant of the	prompts, he will dust, sweep son bedroom space 100% of is cleaning items, will pings, garbage into proper own away or given away, will sting wipes, will use cloth or his mirror or electronics, will after removing bins from dresser and in his closet, bike for 30 minutes with 1 ill correspond with a family in two verbal prompts." If an updated treatment plan with client #2 revealed: lan goal he was aware of y, and I do that."  With the Qualified tial Team Lead (QP/RTL)  Siber 2024	V 112			
	agency "for several yereassigned a month and another another another another agency and agency agenc	ears and his caseload was ago." atment plans would "fall back are not updated as [client #2] scheduled and we are				

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X3) DA A. BUILDING:		(X3) DATE SU COMPLE	ATE SURVEY MPLETED		
		MHL0411266	B. WING		10/09	9/2024		
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE  1400 SPRINGTREE COURT								
MONARCI	H DBA UMAR-ERVIN		NT, NC 27265	N I				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETE DATE		
V 112	Continued From page	e 4	V 112					
	within the next week	and submit it."						

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