STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0411101	A. BUILDING: _____ B. WING _____	10/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
M & S CREEKSIDE	7312 FRIENDSHIP CHURCH ROAD BROWN SUMMIT, NC 27214

(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 An annual survey was completed on October 14, 2024. 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 4 and has a current census of 4. The survey sample consisted of audits of 3 current clients.	V 000		
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 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.	V 108		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0411101	A. BUILDING: _____ B. WING _____	10/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
M & S CREEKSIDE	7312 FRIENDSHIP CHURCH ROAD BROWN SUMMIT, NC 27214

(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 1 (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 each staff had a valid First Aid and Cardiopulmonary Resuscitation (CPR) training certificate. The findings are: Reviews on 10/10/24 and 10/11/24 of each staff's (#1 through #7) personnel records revealed: -Staff #1 with a hire date of 9/30/22 as a Direct Care Technician (DCT) had a 4/16/24 American Red Cross (ARC) training certificate for Adult First Aid/CPR with former staff #8's digital code on the certificate and a completed training date of 9/3/20. -Staff #2 with a hire date of 4/1/17 as a DCT had a 1/15/24 ARC training certificate for Adult First Aid/CPR with former staff #8's digital code on the certificate and a completed training date of 9/3/20. -Staff #3 with a hire date of 6/1/17 as a DCT had a 1/17/23 ARC training certificate for Adult First Aid/CPR with former staff #8's digital code on the certificate and a completed training date of 9/3/20. -Staff #4 with a hire date of 7/7/16 as a DCT had a 7/19/24 ARC training certificate for Adult First Aid/CPR with former staff #8's digital code on the certificate and a completed training date of 9/3/20.	V 108		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0411101	A. BUILDING: _____ B. WING _____	10/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
M & S CREEKSIDE	7312 FRIENDSHIP CHURCH ROAD BROWN SUMMIT, NC 27214

(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 2 -Staff #5 with a hire date of 11/30/21 as a DCT had a 11/24/23 ARC training certificate for Adult First Aid/CPR with former staff #8's digital code on the certificate and a completed training date of 9/3/20. -Staff #6 with a rehire date in 3/2023 as a DCT had a 3/1/24 ARC training certificate for Adult First Aid/CPR with former staff #8's digital code on the certificate and a completed training date of 9/3/20. -Staff #7 with a hire date of 1/30/20 as a DCT had a 7/12/24 ARC training certificate for Adult First Aid/CPR with former staff #8's digital code on the certificate and a completed training date of 9/3/20. Review on 10/11/24 of the Former Director/Qualified Professional (QP)'s ARC certificate revealed: -5/30/24, he was certified as an ARC First Aid and CPR instructor. Review on 10/11/24 of the Director/QP's ARC certificate revealed: -9/20/24, she was certified as an ARC First Aid and CPR instructor. Interviews on 10/10/24 with Staff #1, #2 and #3 revealed: -Each staff stated they received their Adult First Aid and CPR training from the Former Director/QP. Interview on 10/11/24 with the Director/QP revealed: -Each training certificate through ARC cost money and this was the reason the Former Director/QP used a former staff's ARC training certificate. -She was certain each of the current staff (#1	V 108		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0411101	A. BUILDING: _____ B. WING _____	10/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
M & S CREEKSIDE	7312 FRIENDSHIP CHURCH ROAD BROWN SUMMIT, NC 27214

(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 3 through #7) was trained in First Aid and CPR by the Former Director/QP. -She would have the staff's ARC training certificates corrected.	V 108		
V 114	27G .0207 Emergency Plans and Supplies 10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES (a) Each facility shall develop a written fire plan and a disaster plan and shall make a copy of these plans available to the county emergency services agencies upon request. The plans shall include evacuation procedures and routes. (b) The plans shall be made available to all staff and evacuation procedures and routes shall be posted in the facility. (c) Fire and disaster drills in a 24-hour facility shall be held at least quarterly and shall be repeated for each shift. Drills shall be conducted under conditions that simulate the facility's response to fire emergencies. (d) Each facility shall have a first aid kit accessible for use. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to hold fire and disaster drills quarterly for each shift and hold drills which simulated fire emergencies.The findings are:	V 114		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0411101	A. BUILDING: _____ B. WING _____	10/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
M & S CREEKSIDE	7312 FRIENDSHIP CHURCH ROAD BROWN SUMMIT, NC 27214

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 114	Continued From page 4 Reviews on 10/9/24 and 10/11/24 of Client #1's record revealed: -Admission date of 6/2/19. -Diagnoses of Moderate Intellectual Developmental Disability (IDD), Osteopenia, Gastroesophageal Reflux Disease (GERD), Chronic Leukopenia, Discoid Lupus, Seizure Disorder and Static Encephalopathy. -12/1/23 treatment plan revealed: -Client#1 was no longer able to walk or bear weight on her legs and had "limited use" of her leg leg and left arm. -She needed "maximum assistance with all bed mobility and transferring from supine (laying facing up) to sitting, and transferring to bed, wheelchair and recliner," and assistance with bathing, dressing, and toileting." Review on 10/9/24 of Client #2's record revealed: -Admission date of 11/25/23. -Diagnoses of Autistic Disorder, Obsessive Compulsive Disorder, Anxiety Disorder, Dermatillomania, Episodic Temper Tantrums, Scoliosis, and Intermittent Urinary Incontinence. Reviews on 10/9/24 and 10/11/24 of Client #3's record revealed: -Admission date of 12/18/23. -Diagnoses of Mild IDD, Cerebral Palsy, Epilepsy, Depressive Disorder, Dysthymic Disorder, Enuresis, Encopresis and Congenital Quadriplegia. -2/1/24 treatment plan revealed: -Client #2 was non-ambulatory. -"Extensive supports needed for lifts and transfers; uses a hoyer at day program and at home, 2:1 (staff to client ratio) is preferred especially if transitioning from one area to another ...". Due to client's limitations, she requires hands-on support and physical assist	V 114		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0411101	A. BUILDING: _____ B. WING _____	10/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
M & S CREEKSIDE	7312 FRIENDSHIP CHURCH ROAD BROWN SUMMIT, NC 27214

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 114	Continued From page 5	V 114		

with completion of self-help and daily living tasks. She requires physical assist w/ turning, repositioning and toileting on a daily basis."

Review on 10/9/24 of Client #4's record revealed:
-Admission date of 11/1/11.
-Diagnoses of Depressive Disorder, Mood Disorder (hyperactive impulse), Mild IDD and seizure disorder.

Review on 10/10/24 of the fire and disaster log from November 26, 2023 to October 5, 2024 revealed:
-Each fire drill and disaster drill page was titled as a "Fire Drill" or "Natural Disaster Drill" with 1st, 2nd and 3rd staff shifts identified.
-Each staff shift section had designated spaces for staff entry of the date and time of a drill was conducted, a description of a drill, and each client name had a circle beside their name.
-No written instructions were on the log for how staff were to document who participated in a drill.
-Staff signatures on the fire and disaster drill logs were Staff #1, # 2, #3, and the Director/Qualified Professional (Director/QP).

-1st quarter (January 2024 through March 2024):
-No 1st shift fire drill and no simulated 1st shift disaster drill.
-2nd shift fire drill on 2/6/24 (weekday) at 3:35 pm had an "x" mark beside Client #1's name and an "x" mark and "no" in parentheses beside Client #3's name.
-3rd shift fire drill on 3/10/24 (weekend) at 7:00 am had an "x" mark and "no" beside Client #3's name.

-2nd quarter (April 2024 through June 2024)
-1st shift fire drill on 4/7/24 (weekend) at 10:15 am had an "x" beside Client #1's name and an "x"

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0411101	A. BUILDING: _____ B. WING _____	10/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
M & S CREEKSIDE	7312 FRIENDSHIP CHURCH ROAD BROWN SUMMIT, NC 27214

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 114	Continued From page 6	V 114		

mark and "no" beside Client #3's name.
-A second 1st shift fire drill on 5/11/24 (weekend) at 11:35 am had an "x" beside Client #1's name and an "x" mark and "no" beside Client #3's name.
-No 2nd shift fire drill based on 6/11/24 at 3:35 pm documentation which stated (clients) "exited from van and stayed in driveway."
-3rd shift fire drill on 4/21/24 (weekend) at 7:00 am had "no" marked beside Client #3's name.
-1st shift disaster drill on 6/1/24 (weekend) at 12:00 had "no" marked beside Client #3's name.
-2nd shift disaster drill on 6/11/24 (weekday) at 3:40 pm had no marks beside the name of each client (Clients #1, #2, #3 and #4) to identify who participated in the drill.
-No 3rd shift disaster drill.

-3rd quarter (July 2024 through September 2024):
-1st shift fire drill on 7/28/24 (weekend) at 9:50 am had "no" marked beside Clients #1 and #3's names.
-Two additional 1st shift fire drills were documented-one on 9/7/24 (weekend) at 12:40 pm and one on 9/10/24 (weekday) at 1:15 pm with an "x" marked beside Client #1's name.
-No 2nd shift fire drill and no 3rd shift disaster drill.
-3rd shift fire drill on 7/6/24 (weekend) at 7:00 am had no marks in the circles beside the client names to identify who participated in the drill.
-2nd shift disaster drill on 8/7/24 (weekday) at 3:50 pm had no marks in the circles beside the client names to identify who participated in the drill.

-4th quarter (November 2023, December 2023 and October 2024):
-1st shift fire drill on 10/5/24 (weekend) at 1:00 pm with "x" marks beside Clients #1 and #3

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0411101	A. BUILDING: _____ B. WING _____	10/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
M & S CREEKSIDE	7312 FRIENDSHIP CHURCH ROAD BROWN SUMMIT, NC 27214

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 114	Continued From page 7	V 114		

names.
-No 2nd or 3rd shift fire drills.
-1st shift disaster drill on 12/10/23 (weekday) at 9:10 am had no marks in the circles beside the client names to identify who participated in the drill.
-2nd shift disaster drill on 11/14/24 (weekday) at 4:45 pm had no marks in the circles beside the client names to identify who participated in the drill.
-3rd shift disaster drill on 11/26/23 (weekday) at 6:55 am documented "spoke about flood" by Staff #2 and was not a simulated disaster drill. There were no marks in the circles beside the client names to identify who participated in the drill.

Interviews on 10/9/24, 10/10/24 and 10/11/24 with Client #1 revealed:
-"Yes, they (staff) do fire drills."
-"I stay in bed when they do them (fire drills). They (staff) would have to put me in my wheelchair to go outside."
-"No" when asked if staff had ever gotten her out of bed to participate in a fire and disaster drills. "A bell rings loud and it tells me they're doing them (fire drills)."
-"Me and [Client #3], the other girl who can't walk, stay in our beds."
-"I think we do a fire drill when we're outside and getting ready to go to our day program. We're in the driveway getting ready to get on the van."
-"When doing fire drills at night, [Clients #2 and #4] participate all the time."
-"They (Staff #3, #5 and the Director/QP) said they don't want us to get hurt" as the reason why they did not get out of bed during fire drills.
-"I don't know about tornado drills," when asked if she participated in tornado or flood drills.

Interview on 10/9/24 with Client #2 revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0411101	A. BUILDING: _____ B. WING _____	10/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
M & S CREEKSIDE	7312 FRIENDSHIP CHURCH ROAD BROWN SUMMIT, NC 27214

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 114	Continued From page 8 -"Just me and [Client #4]" in response to who is involved with the fire drills. -"No tornado drills." Interviews on 10/9/24, 10/10/24 and 10/11/24 with Client #3 revealed: -"They (Clients #2 and #4) do them but I don't participate. The other one (Client #1) who can't walk doesn't participate either. I stay in bed. I know they're doing a drill because they make a loud noise and I hear that." -It did not bother her when she did not participate in the fire and disaster drills. -"My main concern is what would they (staff) do if there was a fire during the night. This worried me when I came here and was one of my first questions to [Director/QP]. She didn't give me a defined answer." -"I'm involved in a drill if we're already heading toward the van to come over here (day program). We're in the driveway. I just know it's a drill." -She had not been involved in a disaster drill such as tornado or flood since she was admitted to the facility. -"It really concerns me what if we really have a fire in the middle of the night. I know they (staff) can get the other two ladies (Clients #2 and #4) out but there's me and another lady (Client #1) and we're both in wheelchairs. We are much more difficult to handle. 2 staff would ease my mind better than 1 person (staff) in the house (facility) at night in case something happens and we have to get out ...they (staff) got to plan for these things, good, bad or indifferent." Interview on 10/10/2 with Staff #1 revealed: -She worked on 3rd shift from 11:30 pm to 6:30-7:00 am as a direct care staff. -She was awake staff and she was the only staff on her shift.	V 114		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0411101	A. BUILDING: _____ B. WING _____	10/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
M & S CREEKSIDE	7312 FRIENDSHIP CHURCH ROAD BROWN SUMMIT, NC 27214

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 114	Continued From page 9	V 114		

-"I usually do them (fire and disaster drills) early in the morning."
-"I don't do drills with [Client #1] and [Client #3] because there's no extra staff, but I will wait until another staff comes to do one (drill) so [Client #1] and [Client #3] can be a part of the drill."
-"I will do a fire drill with [Client #2] and [Client #4] going outside and then do another one when we can take them all outside. [Owner] or [Director/QP] will help me in assisting them (Clients #1 and #3) outside."
-"I let them (Clients #1 and #3) know about us doing the fire drill."
-"When we do that (tornado drill), we close all the doors and get in the hallway. No [Client #1] and [Client #3] doesn't go to the hallway. They stay in their beds. I just let them know what's going on and be aware of the situation."
-She thought she had discussed not getting Clients #1 and #3 up for drills with the Director/QP. "I can't tell you when I discussed this with her."
-"Everyone knows it could be a mess to try and get them (Clients #1, #2, #3 and #4) up at night and I'm not going to wake them up. The only option is to do a drill in the morning."
-"If it was a real fire, I would do the best I could to get everyone out. I would get the next-door neighbor to help."
-An "x" marked in the circle beside a client's name on the fire and disaster logs meant they did not participate in a drill. A check mark beside their name meant they (clients) participated in a drill.
-"If there were circles beside their (clients') names, it was probably overlooked."

Interview on 10/10/24 with Staff #2 revealed:
-She worked on 3rd shift (11:30 pm- 7:30 am) as a direct care staff.
-She was awake staff and she was the only staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0411101	A. BUILDING: _____ B. WING _____	10/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
M & S CREEKSIDE	7312 FRIENDSHIP CHURCH ROAD BROWN SUMMIT, NC 27214

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 114	Continued From page 10	V 114		

on her shift.
-"If we (staff) do a drill on my shift, we do not do one during the night."
-"The situation is we have 2 bedridden clients. I would do the drills in the morning when [Director/QP] comes to help because I would have help getting them (Clients #1 and #3) out (outside)."
-"I do the same with them (tornado drills). I don't do them (drills) in the middle of the night ... I do them (drills) in the morning."
-"I would have to use my brain power to make my best effort to get them (Clients #1 and #3 out in an actual fire. I be thinking about it too. Ambulatory clients (Clients #2 and #4) would be able to get out but not so much the non-ambulatory ones (Clients #1 and #3)."
-She had not had a conversation with the Director/QP about what would happen to evacuate Clients #1 and #3 if a fire occurred at the facility.
-Confirmed that an "x" on the drill log beside a client's name meant the client did not participate in the drill and a "checkmark" meant the client participated in the drill.
-"If blank, I don't know" about no marks in the circles beside client names on the drill log.

Interview on 10/10/24 with Staff #3 revealed:
-She worked alone at the facility as a Direct Care Technician on the weekend 1st shift (Saturday and Sunday) from 7:30 am-3:30 pm, and 2nd shift on Mondays and Tuesdays from 3:00 pm-11:30 pm.
-"I take [Clients #2 and #4] in the hallway" in response to how she conducted fire and disaster drills. "[Clients #1 and #3], they stay in their beds. I can't get them up and push (them) outside by myself. If a real fire came, I would call 911."
- "I've done 1 or 2 tornado drills. I shut their

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0411101	A. BUILDING: _____ B. WING _____	10/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
M & S CREEKSIDE	7312 FRIENDSHIP CHURCH ROAD BROWN SUMMIT, NC 27214

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 114	Continued From page 11 (Clients #1 and #3's) doors and hope nothing happens. It's just hard to do that (close Clients #1 and #3)'s doors." -"If there was a fire, I know I got to call somebody and get help. Tell 911 to get there (to the facility) fast. I can't pick them (Clients #1 and #3) up and take them out ...does bother me how do you get them out. On a fire drill, I tell them 'Y'all stay still.'" -"I know when they (clients) exit the van, fire drills are done. Some mornings we do them (fire drills) as we leave out of the house and they (clients) go to their program ...always have to have 2 people (staff) at the facility to get them (Clients #1 and #3) outside." -"I close all major doors and go in hallway (for tornado drills). They, [Client #1 and #3] don't get up (from bed)." -" I would rather not say" about whether she had discussed her concern with the Director/QP of not involving Clients #1 and #3 in the fire and disaster drills. Interview on 10/10/24 with the Director/QP revealed: -There were 3 staff shifts at the facility. -Staff who conducted the fire and disaster drills were responsible for their documentation of the drills on the log. -"Usually we put an "x" mark or "checkmark" if a person (client) is not there for a drill (fire and disaster drills)." -"I assume they (clients) did the drill if no marks were made (beside clients' names)." -"I am here (at the facility) in the mornings, and I help with that (fire and disaster drills). Staff are not by themselves, and I do not expect them to run drills without 2 staff. We do the best we can." -"It's not a secret they (Clients #1 and #3) stay in bed when drills are run. I try to be here (at facility) during certain times for the drills. It's a real	V 114		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0411101	A. BUILDING: _____ B. WING _____	10/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
M & S CREEKSIDE	7312 FRIENDSHIP CHURCH ROAD BROWN SUMMIT, NC 27214

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 114	Continued From page 12 concern if an actual fire happened." -"These ladies' (clients) health and safety, that's my job. I will do whatever I need to ...I don't mind making adjustments." This deficiency is cross referenced into 10A NCAC 27G .5601 (V289) for a Type A2 rule violation and must be corrected within 23 days.	V 114		
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; (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	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0411101	A. BUILDING: _____ B. WING _____	10/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
M & S CREEKSIDE	7312 FRIENDSHIP CHURCH ROAD BROWN SUMMIT, NC 27214

(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 13 file followed up by appointment or consultation with a physician. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure staff who administered client medications were trained by a legally qualified and privileged person who could prepare and administer medications. The findings are: Reviews on 10/10/24 and 10/11/24 of each staff's (#1 through #7) personnel records revealed: -Staff #1 with a hire date of 9/30/22 had a 10/1/24 Medication Administration training certificate with a 1.0 training hour which was completed through an online training program. -Staff #5 with a hire date 11/30/21 had 11/30/21, 11/15/22 and 11/10/23 Medication Administration training certificates with a 1.0 training hour on each training date and all 3 trainings were completed through an online training program. -Staff #6 with a rehire date of 3/2023 had 6/2/22, 5/30/23 and 5/27/24 Medication Administration training certificates with a 1.0 training hour on each training date and all 3 trainings were completed through an online training program. Interview on 10/10/24 with Staff #1 revealed: -She took her medication training online and then took a written test. Interview on 10/10/24 with the Director/ Qualified Professional (QP) revealed: -There were staff (Staff #2 and Staff #4) who had	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0411101	A. BUILDING: _____ B. WING _____	10/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
M & S CREEKSIDE	7312 FRIENDSHIP CHURCH ROAD BROWN SUMMIT, NC 27214

(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 14 initial medication training through a pharmacy service which was conducted in person, Staff #3 was already a Medication Technician when she started work, and the online medication training was used as a "refresher" training for staff. -She did not know how to get in contact with the registered nurse identified on the online Medication Administration training certificates. -"It's just a program that's been downloaded on computer."	V 118		
V 289	27G .5601 Supervised Living - Scope 10A NCAC 27G .5601 SCOPE (a) Supervised living is a 24-hour facility which provides residential services to individuals in a home environment where the primary purpose of these services is the care, habilitation or rehabilitation of individuals who have a mental illness, a developmental disability or disabilities, or a substance abuse disorder, and who require supervision when in the residence. (b) A supervised living facility shall be licensed if the facility serves either: (1) one or more minor clients; or (2) two or more adult clients. Minor and adult clients shall not reside in the same facility. (c) Each supervised living facility shall be licensed to serve a specific population as designated below: (1) "A" designation means a facility which serves adults whose primary diagnosis is mental illness but may also have other diagnoses; (2) "B" designation means a facility which serves minors whose primary diagnosis is a developmental disability but may also have other diagnoses; (3) "C" designation means a facility which	V 289		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0411101	A. BUILDING: _____ B. WING _____	10/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
M & S CREEKSIDE	7312 FRIENDSHIP CHURCH ROAD BROWN SUMMIT, NC 27214

(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 289	Continued From page 15 serves adults whose primary diagnosis is a developmental disability but may also have other diagnoses; (4) "D" designation means a facility which serves minors whose primary diagnosis is substance abuse dependency but may also have other diagnoses; (5) "E" designation means a facility which serves adults whose primary diagnosis is substance abuse dependency but may also have other diagnoses; or (6) "F" designation means a facility in a private residence, which serves no more than three adult clients whose primary diagnoses is mental illness but may also have other disabilities, or three adult clients or three minor clients whose primary diagnoses is developmental disabilities but may also have other disabilities who live with a family and the family provides the service. This facility shall be exempt from the following rules: 10A NCAC 27G .0201 (a)(1),(2),(3),(4),(5)(A)&(B); (6); (7)(A),(B),(E),(F),(G),(H); (8); (11); (13); (15); (16); (18) and (b); 10A NCAC 27G .0202(a),(d),(g)(1)(i); 10A NCAC 27G .0203; 10A NCAC 27G .0205 (a),(b); 10A NCAC 27G .0207 (b),(c); 10A NCAC 27G .0208 (b),(e); 10A NCAC 27G .0209[(c)(1) - non-prescription medications only] (d)(2),(4); (e)(1)(A),(D),(E);(f);(g); and 10A NCAC 27G .0304 (b)(2),(d)(4). This facility shall also be known as alternative family living or assisted family living (AFL). This Rule is not met as evidenced by: Based on record review and interview, the facility	V 289		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0411101	A. BUILDING: _____ B. WING _____	10/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
M & S CREEKSIDE	7312 FRIENDSHIP CHURCH ROAD BROWN SUMMIT, NC 27214

(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 289	Continued From page 16 failed to provide services to meet the needs of the clients (Clients #1, #2, #3 and #4). The findings are: Cross Reference: 10A NCAC 27G .0207 Emergency Plans and Supplies (V114). Based on record review and interview, the facility failed to hold fire and disaster drills quarterly for each shift and hold drills which simulated fire emergencies. Cross Reference: 10A NCAC 27G .5602 Staffing (V290). Based on record review and interview, the facility failed to ensure staffing to respond to the individual client needs for 2 of 3 audited clients (Clients #1 and #3). Review on 10/9/24 of the facility's 2024 license application with the North Carolina Division of Health Service Regulation revealed: -The facility was licensed for 4 clients with 4 ambulatory clients and 0 non-ambulatory clients. Interview on 10/10/24 with the Director/Qualified Professional (QP) revealed: -"I made a mistake on the number of ambulatory and non-ambulatory clients (on the facility's license application)." -"It should have been 2 ambulatory and 2 non-ambulatory clients." -" I will do a change form to correct this mistake." Review on 10/12/24 of a Plan of Protection dated 10/11/24 and completed by the Director/QP revealed: "What immediate action will the facility take to ensure the safety of the consumers in your care? -Effective 10/12/24 additional staff will be on the premises. All staff working the weekend shifts will review how to contact all emergency services, will review the list of important contacts that can help	V 289		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0411101	A. BUILDING: _____ B. WING _____	10/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
M & S CREEKSIDE	7312 FRIENDSHIP CHURCH ROAD BROWN SUMMIT, NC 27214

(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 289	Continued From page 17	V 289		

during an emergency, recognize exit routes and doorways, check medical equipment such as hoyer lift, understand emergency plan to include evacuation route and procedures, location of fire extinguishers and proper use of fire extinguishers. All meeting location will be pointed out depending on the exit door. Client #1, Client #2, Client #3, and Client #4 will also be advised of all emergency procedures and plans for evacuation.

Describe your plans to ensure the above happens.
-QP (Director/QP) will be on premises for the weekend on each shift to speak to the DCT (Direct Care Technician) that is working. QP will go over all emergency service numbers. QP will go over and post important contact numbers of individuals whom may need to be contacted during an emergency. QP will go over all possible door exits and best routes depending on location of emergency. QP (Director/QP) will demonstrate and check all medical devices to include hoyer lift. QP will go over the emergency plan to include evacuation procedures and evacuation routes. QP will point out fire extinguishers and review how and when to use fire extinguishers. QP will have conversations and demonstration with client #1, client#2, client#3 and client #4 about emergency plans and evacuation procedures. QP will go over all exit routes, and possible situation like fire or natural disaster. QP will go over the importance of listening to the instruction of the staff person whom is trying to assist them. QP will discuss meeting locations depending on the exit route."

Review on 10/14/24 of an amended Plan of Protection dated 10/14/24 and completed by the Director/QP revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0411101	A. BUILDING: _____ B. WING _____	10/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
M & S CREEKSIDE	7312 FRIENDSHIP CHURCH ROAD BROWN SUMMIT, NC 27214

(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 289	Continued From page 18 -"What immediate action will the facility take to ensure the safety of the consumers in your care? -M&S Supervised Living LLC (Licensee) will conduct fire and disaster drills on each shift at least quarterly. The drills will be conducted under conditions that simulate fire emergencies. Client #1, client #2, client #3, and client #4 will be included in all drills. -M&S Supervised Living LLC will submit a change of use form to the state to correct the error showing we service only four ambulatory clients. -M&S Supervised Living will continue to have 2 staff on premises to help with fire and disaster drills and individualized client needs for the next 45 to 60 days. Describe your plans to make sure the above happens. -The fire and disaster drills will take place effective 10/14/24 for 2nd shift, 10/15/24 for 1st shift, and 10/16/24 for 3rd shift. All documentation will be completed for each drill. Staff (2) as well as clients will initial participation in all drills. -M&S Supervised Living (Licensee) will submit a change of use request to the state effective 10/15/2024 to correct the error and request the license to support 2 non ambulatory clients. -M&S Supervised Living (Director/QP) will put in an emergency discharge notice for a non -ambulatory client to help ensure the health and safety concerns, and to help staff respond to individual needs of all clients in the home." Review on 10/14/24 of an addendum to the Plan of Protection dated 10/14/24 and completed by the Director/QP revealed: - "After 60 days or discharge of non- ambulatory client whichever may come first, M&S Supervised Living LLC will return to 1 staff person. - The staffing will continue until discharge of one	V 289		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0411101	A. BUILDING: _____ B. WING _____	10/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
M & S CREEKSIDE	7312 FRIENDSHIP CHURCH ROAD BROWN SUMMIT, NC 27214

(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 289	Continued From page 19	V 289		

non ambulatory client, with the understanding that discharge may take longer than 60 days. M&S Supervised Living LLC will work with the team to help with placement as much as necessary. The staff will be trained on all equipment to be used during fire and disaster and will be able to support 1 non-ambulatory individual without concerns about health and safety in the future."

The facility served clients with diagnoses including Mild to Moderate Intellectual Developmental Disability, Autism, Lupus, Seizure Disorder, Encephalopathy, Cerebral Palsy, and Quadriplegia. 2 of the 4 clients (Clients #1 and #3) were non-ambulatory and were required to have full and extensive hands-on assistance with their transfers in and out of bed and to and from their wheelchairs, bathing, toileting, and evacuating the facility during fire and natural disaster drills. There was 1 staff assigned per shift to assist the 2 non-ambulatory and the 2 ambulatory clients (Clients 2 and #4). During fire and natural disaster drills, Clients #1 and #3 stayed in bed and did not participate in the drills when there was 1 staff on duty. Other monthly fire and disaster drills were attempted for staff convenience as Clients #1, #2, #3 and #4 waited in the facility driveway in preparation to go to their day program and upon the clients' return to the facility from their day program while there was 1 staff at the facility and a van transporter available. Client #3 was worried about how she and Client #1 would be able to evacuate the facility if a fire occurred.
This deficiency constitutes a Type A2 rule violation for substantial risk of serious harm and must be corrected within 23 days.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0411101	A. BUILDING: _____ B. WING _____	10/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
M & S CREEKSIDE	7312 FRIENDSHIP CHURCH ROAD BROWN SUMMIT, NC 27214

(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 20	V 290		
V 290	27G .5602 Supervised Living - Staff 10A NCAC 27G .5602 STAFF (a) Staff-client ratios above the minimum numbers specified in Paragraphs (b), (c) and (d) of this Rule shall be determined by the facility to enable staff to respond to individualized client needs. (b) A minimum of one staff member shall be present at all times when any adult client is on the premises, except when the client's treatment or habilitation plan documents that the client is capable of remaining in the home or community without supervision. The plan shall be reviewed as needed but not less than annually to ensure the client continues to be capable of remaining in the home or community without supervision for specified periods of time. (c) Staff shall be present in a facility in the following client-staff ratios when more than one child or adolescent client is present: (1) children or adolescents with substance abuse disorders shall be served with a minimum of one staff present for every five or fewer minor clients present. However, only one staff need be 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	V 290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0411101	A. BUILDING: _____ B. WING _____	10/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
M & S CREEKSIDE	7312 FRIENDSHIP CHURCH ROAD BROWN SUMMIT, NC 27214

(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 21 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 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 respond to the individual client needs for 2 of 3 audited clients (Clients #1 and #3). The findings are: Reviews on 10/9/24 and 10/11/24 of Client #1's record revealed: -Admission date of 6/2/19. -Diagnoses of Moderate Intellectual Developmental Disability (IDD), Osteopenia, Gastroesophageal Reflux Disease (GERD), Chronic Leukopenia , Discoid Lupus, Seizure Disorder and Static Encephalopathy. -12/1/23 treatment plan stated: -Client #1 was no longer able to walk or bear weight on her legs and has "limited use" of her left leg and left arm. -She was "incontinent and requires frequent changing." -She has a history of sacral ulcers. -She "needs maximum assistance with all bed mobility and transferring from supine (laying face up) to sitting, and transferring to bed, wheelchair and recliner," and assistance with bathing, dressing, and toileting." -" ... requires 2-3 staff to get her in the shower chair and get the chair into the shower "so we can	V 290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0411101	A. BUILDING: _____ B. WING _____	10/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
M & S CREEKSIDE	7312 FRIENDSHIP CHURCH ROAD BROWN SUMMIT, NC 27214

(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 22 only do this twice a week." Reviews on 10/9/24 and 10/11/24 of Client #3's record revealed: -Admission date of 12/18/23. -Diagnoses of Mild IDD, Cerebral Palsy, Epilepsy, Depressive Disorder, Dysthymic Disorder, Enuresis, Encopresis, and Congenital Quadriplegia. -2/1/24 treatment plan stated: -"Requires hands-on support and physical assistance with completion of self-help and daily living tasks (toileting, bathing, dressing, and food preparation) ...due to cerebral palsy and spastic quadriplegia." -"Extensive supports needed for turning and repositioning in bed ...for lifts and transfers." -"2:1 (staff to client ratio) preferred especially if transitioning from one area to another." Interviews on 10/9/24, 10/10/24 and 10/11/24 with Client #1 revealed: -"I can't walk. That's why I'm in this wheelchair." -During the weekday mornings, 1 staff helped her sponge bathe, dress, and transfer her from her bed into her wheelchair. A 2nd staff came to the facility and helped Client #3 get ready to go to the day program. Both staff helped her and Client #3 get on the van to be transported to their day program. -"It's (staff) whoever is working in the morning. [Director/Qualified Professional (QP)] comes in to help us and drives us here (to the day program)." -On weekends, the Director/QP "sometimes" came to help the staff on duty get her out of her bed for a shower and wash her hair. -"I'm not up on Saturdays or Sundays because they (staff) want me to rest my butt." -There was 1 staff was on 3rd shift "because we're (Clients #1, #2, #3 and #4) all in bed."	V 290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0411101	A. BUILDING: _____ B. WING _____	10/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
M & S CREEKSIDE	7312 FRIENDSHIP CHURCH ROAD BROWN SUMMIT, NC 27214

(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 23	V 290		

-She did not participate in fire or tornado drills when there was 1 staff on a shift.
-She participated in fire drills when she and her housemates (Clients #2, #3 and #4) were outside (the facility) and waiting to be transported to their day program.

Interviews on 10/9/24, 10/10/24, 10/11/24 and 10/14/24 with Client #3 revealed:
-She was admitted to the facility from a nursing home in December last year (2023).
-"I can't walk and I have to have full care with transferring in and out of my wheelchair, having my diaper changed, dressing and bathing."
-She did not have a 1:1 staff assigned to provide care to her at the facility.
-"I would have to have 2 people (staff) lift me ...I'm dead weight ...2 staff would ease my mind better than 1 person (staff) in the house at night in case something happens ..."
-She stayed in bed when she returned to the facility during the weekdays from her day program and until the next morning.
-"I stay in bed on Saturdays and Sundays. 1 staff is there (at facility) on weekends. If [Director/QP] and another staff were there, I might get up for a while but I wouldn't trust 1 staff with me because I have so many things like osteoporosis and had broken bones."

Interview on 10/10/24 with Staff #1 revealed:
-"When I work at night, its just me. If I need to assist clients with lifting, I can call [Director/QP]."
-In the mornings, she gave Client #1 a sponge bath and assisted her in getting dressed.
-Client #3 "will tell you what she wants done right then and there. She will say 'I need you to come here now and change me.' I may be assisting [Client #1] and I tell her (Client #3) I will be right there when I'm done with [Client #1]."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0411101	A. BUILDING: _____ B. WING _____	10/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
M & S CREEKSIDE	7312 FRIENDSHIP CHURCH ROAD BROWN SUMMIT, NC 27214

(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 24 -She waited until a 2nd staff came in at the facility to run a fire and disaster drill for Clients #1 and #3 to participate in "because there's no extra staff to help get them up." Interview on 10/10/24 with Staff #2 revealed: -She worked 3rd shift as the only staff on duty. -"I can't get them up with just me there (at facility). I have to wait until a morning relief (staff) comes in for loading them (clients) on the van for the day program." Interview on 10/10/24 with Staff #3 revealed: -She worked the weekend shift, Saturdays and Sundays from 7:30 am to 3:30 pm and 2nd shift on Mondays and Tuesdays from 3:00 pm-11:30 pm. -"[Client #1] can't stand and can't walk." -"We (Staff #3 and whoever the van transport staff was) get her (Client #1) in the bed when she comes home from the day program." -"There has to be 2 of us (staff) to get her (Client #1) in her wheelchair to take a shower. I give her a sponge bath when its just me." -Client #3 "can't do nothing for herself. One of the girls (staff) on 3rd shift along with [Director/QP] puts her in the shower ...I take a wash rag and clean her up." -On weekends, Client #3 stayed in her bed, watched TV and talked to her electronic voice service device. -"I be alone (on shift) and if something happens, I will call [Director/QP] or [Owner #2]." Interviews on 10/10/24 through 10/14/24 with the Director/QP revealed: -The facility was "fully staffed in the mornings with 2 staff to care for everyone (Clients #1, #2, #3 and #4). They (Clients #1 and #3) are the hardest to care for with transferring them into their	V 290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0411101	A. BUILDING: _____ B. WING _____	10/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
M & S CREEKSIDE	7312 FRIENDSHIP CHURCH ROAD BROWN SUMMIT, NC 27214

(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 25 wheelchairs and I am helping, or I have another staff here (at the facility)." -"Either I or another staff are here to help load everyone (Clients #1, #2, #3 and #4) on the van for the day program." -The day program operated Monday through Friday from 9:00 am to 3:00-3:30 pm. -Either she or another staff was at the facility with a 2nd shift staff to unload the clients from the van and get Clients #1 and #3 transferred into their beds. -Staff could call her any time they needed additional help with the clients. -"These ladies' (clients') health and safety, that's my job. I will do whatever I need to for them to be safe." -She stated if she hired 2 staff for each shift, including weekends, she would be "upside down" financially. -She was willing to discharge any client if they did not feel safe in the facility. -She was putting in an emergency discharge for Client #3 and stated, "the reasons for discharge are if an individual does not feel safe or has fear and I can't do something to make it safe, they need to be somewhere they feel safe" and "I cannot afford 2 staff on each shift at that home (facility)." This deficiency is cross referenced into 10A NCAC 27G .5601 (V289) for a Type A2 rule violation and must be corrected within 23 days.	V 290		
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	V 540		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0411101	A. BUILDING: _____ B. WING _____	10/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
M & S CREEKSIDE	7312 FRIENDSHIP CHURCH ROAD BROWN SUMMIT, NC 27214

(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 26 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 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 record review and interview, the facility failed to assure each client the right to be provided an opportunity for a shower or tub bath daily or more often as needed. The findings are: Reviews on 10/10/24 and 10/11/24 of Client #1's record revealed: -Admission date of 6/2/19. -Diagnoses of Moderate Intellectual Developmental Disability (IDD), Osteopenia, Gastroesophageal Reflux Disease (GERD), Chronic Leukopenia , Discoid Lupus, Seizure Disorder and Static Encephalopathy. -12/1/23 treatment plan stated she "required 2-3	V 540		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0411101	A. BUILDING: _____ B. WING _____	10/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
M & S CREEKSIDE	7312 FRIENDSHIP CHURCH ROAD BROWN SUMMIT, NC 27214

(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 27	V 540		

staff to get her in the shower chair and get the chair into the shower with a statement "so we can only do this (showering) twice a week."

Reviews on 10/10/24,10/11/24 of Client #3's record revealed:
-Admission date of 12/18/23.
-Diagnoses of Mild IDD, Cerebral Palsy, Epilepsy, Depressive Disorder, Dysthymic Disorder, Enuresis, Encopresis, and Congenital Quadriplegia.
-2/1/24 treatment plan stated:
-"Requires hands-on support and physical assistance with completion of self-help and daily living tasks (toileting, bathing, dressing, and food preparation) ...due to cerebral palsy and spastic quadriplegia."

Interview on 10/9/24 with Client #1 revealed:
-"I take sponge bath in the mornings but when [Director/Qualified Professional (QP)] and whatever staff is present there (at facility), they help me into the shower."
-Her sponge baths were given to her in the mornings by 1 staff.
"I'm okay not taking a shower every day. I don't think I need once every day."

Interview on 10/14/24 with Client #3 revealed:
-She takes a "bed bath" in the mornings to bathe.
-"I might get up and get in the shower every so often to get my hair washed. It would take 2 people (staff) to get me up and in the shower."
-"I'm waiting on my shower chair. Been a good minute" in response to how long she had been waiting on her shower chair.

Interview on 10/10/24 with Staff #1 revealed:
-She helped Client #1 with a sponge bath and getting dressed in the mornings when she was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0411101	A. BUILDING: _____ B. WING _____	10/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
M & S CREEKSIDE	7312 FRIENDSHIP CHURCH ROAD BROWN SUMMIT, NC 27214

(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 28 the only staff on duty. Interview on 10/10/24 with Staff #2 revealed: -Clients #1 and #3 were "incapable of bathing themselves." -Client #1 partly helped with her bed bathing and Client #3 could not bathe herself at all; she (Staff #2) had to turn and reposition Client #3 in bed while bathing her. -"I can't get them (Clients #1 and #3) up with just me. I have to wait until my morning relief comes in to get them up ..." Interview on 10/10/24 with Staff #3 revealed: - "[Client #1] be in the bed when I go in (on her shift). There has to be 2 of us to get in her wheelchair to take her for a shower. I give her a sponge bath when it's just me. [Director/QP] and [Facility Owner #1] gives her a shower." -She did not know how often Client #1 was offered a shower. -One of the 3rd shift staff along with the Director/QP put Client #3 in the shower. -She cleaned Client #3 up in bed when needed. Interview on 10/4/24 with the Director/QP revealed: -Since Client #1's treatment team meeting for her 12/ 1/23 treatment plan, Client #1 had received a shower chair that doubled as a commode with a slider which was used to transfer her on from her wheelchair and slide her into and out of the shower. -She assisted Client #1 with a shower once or twice a week. -She did not offer Client #1 opportunity to shower daily. -"She doesn't fuss about showers. She complains when staff check her in bed for wetness." -" With [Client #3], we do the best we can to get	V 540		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0411101	A. BUILDING: _____ B. WING _____	10/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
M & S CREEKSIDE	7312 FRIENDSHIP CHURCH ROAD BROWN SUMMIT, NC 27214

(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 29 her up to shower but she still has not received her shower chair."	V 540		
V 772	27G .0304(d)(6) Residential Facilities Without Elevators 10A NCAC 27G .0304 FACILITY DESIGN AND EQUIPMENT (d) Indoor space requirements: Facilities licensed prior to October 1, 1988 shall satisfy the minimum square footage requirements in effect at that time. Unless otherwise provided in these Rules, residential facilities licensed after October 1, 1988 shall meet the following indoor space requirements: (6) In a residential facility licensed under residential building code standards and without elevators, bedrooms above or below the ground level shall be used only for individuals who are capable of moving up and down the steps independently. This Rule is not met as evidenced by: Based on record review, observation, and interview, the facility failed to ensure a client bedroom which was above ground level was used for a clients who was capable of moving up and down steps independently. The findings are: Reviews on 10/10/24 and 10/11/24 of Client #1's record revealed: -Admission date of 6/2/19. -Diagnoses of Moderate Intellectual Developmental Disability (IDD), Osteopenia, Gastroesophageal Reflux Disease (GERD), Chronic Leukopenia , Discoid Lupus, Seizure Disorder and Static Encephalopathy.	V 772		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0411101	A. BUILDING: _____ B. WING _____	10/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
M & S CREEKSIDE	7312 FRIENDSHIP CHURCH ROAD BROWN SUMMIT, NC 27214

(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 772	Continued From page 30 -12/1/23 treatment plan stated "[Client #1] continues to require a high level of full and partial physical supports. She is no longer able to walk or bear weight on her legs." Observation on 10/10/24 of the facility between 3:10 pm and 3:50 pm revealed: -Client #1's bedroom had a door that opened up to the backyard of the facility with an attached wood deck that was approximately 5-6" in width and had at least 6 wooden steps from top of the deck to ground level. Interview on 10/10/24 with Client #1 revealed: -She did not exit the door in her room to go outside. -She went through the hallway in her wheelchair to the large living room and exited the door to the outside using the wheelchair ramp. Interview on 10/10/24 with the Director/Qualified Professional revealed: -Client #1 did not use the door in her bedroom to exit out of the facility. -She stated that the accreditation organization who visited the facility in September 2024 recommended a wheelchair ramp be built on the deck outside Client #1's room and she was looking into getting a ramp built. She was aware she needed involvement from the construction section for the ramp to be built. -Client #1's bedroom was the master bedroom because Client #1 had a lot of equipment. -She looked online about a method of transferring Client #1 on a mattress with an extender to lower Client #1 down with the mattress in the event of fire in the hallway and she needed Client #1 to be evacuated through the door in her room.	V 772		