Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		MHL034-413	B. WING		10/23/2024	
NAME OF PI	ROVIDER OR SUPPLIER		RESS, CITY, STA	TE, ZIP CODE		
MONARCI	H DBA UMAR-WADDELL		IOLDA ROAD SALEM, NC 2	7104		
(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)		ETE
V 000	V 000 INITIAL COMMENTS An annual survey was completed on October 23, 2024. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities. This facility is licensed for 6 and has a current census of 6. The survey sample consisted of audits of 3 current clients.		V 000			
V 112	27G .0205 (C-D) Assessment/Treatme	nt/Habilitation Plan	V 112			
	10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (c) The plan shall be developed based on the assessment, and in partnership with the client or legally responsible person or both, within 30 days of admission for clients who are expected to receive services beyond 30 days. (d) The plan shall include: (1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement; (2) strategies; (3) staff responsible; (4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both; (5) basis for evaluation or assessment of outcome achievement; and (6) written consent or agreement by the client or responsible party, or a written statement by the provider stating why such consent could not be obtained.					

Division of Health Service Regulation LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

Division of Health Service Regulation

		(X1) PROVIDER/SUPPLIER/CLIA			(X3) DATE SURVEY COMPLETED	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _	A. BUILDING:		LETED
		MHL034-413	B. WING		10	23/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	ΓE, ZIP CODE		
MONARC	LI DDA LIMAD WADDELL	1323 RE	YNOLDA ROAD			
WONARC	H DBA UMAR-WADDELL	WINSTO	N-SALEM, NC 27	7 104		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
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IAO		,	ino	DEFICIENC		
V 112	Continued From page	2.1	V 112			
V 112	Continued From page	3 1	V 112			
	This Rule is not met	as evidenced by:				
		ews and interviews, the				
		e the treatment/habilitation				
	or service plan at leas	st annually with the client or				
		erson for 2 of 3 audited				
	clients (#2 and #3). T	he findings are:				
	Review on 10/22/24 o	of client #2's record				
	revealed:	or cheft #23 record				
	-An admission date o	f 10/22/01				
		Syndrome and Rheumatoid				
	Arthritis	•				
	-Age 43					
		d 3/12/01 noted "is short in				
		wly and cautiously due to				
		noted behavioral issues,				
	medical issues do ap					
	0.0	oss and fine motor skills running, jumping, poor				
	, ,	rstanding of those that may				
		pervision at all times except				
		urage participating in the				
		ourage her desire to read, to				
		works, and has a full IQ				
	score of 62."					
		f a treatment/habilitation or				
	service plan.					
	Review on 10/22/24 o	of client #3's record				
	revealed:	on chichit #0 5 record				
	-An admission date o	f 7/11/13				
	-Diagnoses of Chroni					

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DIVISION	n nealth Service Regu	lation				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE			URVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
			/ DOILDING			
	MHL034-413		B. WING		10/2	3/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		1323 REY	NOLDA ROAD			
MONARCI	H DBA UMAR-WADDELL	WINSTON	-SALEM, NC 2	7104		
			T			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
PREFIX		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX	CROSS-REFERENCED TO THE APPROPR		DATE
TAG	REGOLATORY OR E	100 IDENTIF TINO INFORMATION)	TAG	DEFICIENCY)	WATE	
				,		
V 112	Continued From page	2	V 112			
	. •					
	Developmental Disord	der, Moderate Mental				
	Retardation, Chronic	Hepatitis B and Overactive				
	Bladder	·				
	-Age 31					
	-An assessment date	d 7/11/13 noted "nost				
		ome due to abuse and				
	•	n orphanage until nearly 4				
	,	s actively involved, attends				
	the Enrichment Cente	er and has a job coach, does				
	not need assistance v	vith personal care, is very				
	social, a hard worker	and always has a smile,				
		cks, needs employment				
	support, transportation					
		•				
	_	term plan as her parents				
		only needs reminders with				
		ents, needs reminders with				
	combing and brushing	g hair, needs help with				
	wardrobe maintenand	ce, needs to learn safety				
	skills, doesn't compre	hend spending limits, will				
		sometimes fixate on a				
	topic."					
		a treatment/habilitation or				
		a treatment/habilitation of				
	service plan.					
		with client #2 revealed:				
	-Her goal was to keep	her room clean				
	Interview on 10/22/24	with client #3 revealed:				
	-Goals included "how	to wash my hair and brush				
		s forget to put on deodorant.				
		elean. I worked on it last				
		earn how to do my laundry. I				
	am good at sorting the	em right now."				
	Interview on 10/23/24	with staff #1 revealed:				
	-Worked on client #1,	#2 and #3's treatment				
	goals daily.					
	,					
	Interview on 10/23/24	with the Residential Team				
		the reconstitution	1	1		

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Lead revealed:

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` '		1 ' '	X3) DATE SURVEY COMPLETED	
		MHL034-413	B. WING		10/2	3/2024	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE			
MONARCI	H DBA UMAR-WADDELL	1323 REYN	IOLDA ROAD				
WIONARC	II DDA OWAK-WADDELL	WINSTON-	SALEM, NC 2	7104			
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETE DATE	
V 112	Continued From page	3	V 112				
	-The Vice President of Operations was unable to locate updated treatment plans for client #2 and client #3						
V 290	27G .5602 Supervise	d Living - Staff	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						

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
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NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE, ZIP CODE	1	
MONARC	H DBA UMAR-WADDELL		NOLDA ROAD SALEM, NC 2	7104		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
V 290	diagnosis is substance (1) at least one duty shall be trained i withdrawal symptoms secondary complication drug addiction; and	verning body. serve clients whose primary se abuse dependency: staff member who is on n alcohol and other drug and symptoms of ons to alcohol and other s of a certified substance I be available on an	V 290			
	This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure a minimum of one staff was present at all times when a client was on the premises, except when the client's treatment or habilitation plan documented that the client was capable of remaining in the home or community without supervision affecting 3 of 3 clients (#1, #2, and #3).					
	revealed: -No facility staff were -A client spoke throug stated for FCC to wal "because no staff is h Further observation of the facility revealed: -Staff #1 arrived at the -Client #1 and client #	h the closed door and k to the sister facility				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING:			(X3) DATE SURVEY COMPLETED	
			71. 201231110.	A. BOILBING.		
		MHL034-413	B. WING		10	0/23/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	. ZIP CODE		
			YNOLDA ROAD	,		
MONARC	H DBA UMAR-WADDELL	•	N-SALEM, NC 271	04		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	COMPLETE DATE
V 290	Continued From page	e 5	V 290			
V 290	facility revealed: -Client #3 arrived at the 10/22/24 Staff #1 arrived at the groceries. Stated she trying to do too many short staffed. Started joes for lunch. Staff w. Review on 10/22/24 or revealed: -An admission date or -Diagnoses of Mild M. Ventricular Septal De Chromosome Abnormander -Age 52 -An assessment date leg brace on her left limearing and has had family is very support is her own guardian, and care, is independent or reading, sports, exercing group home activities. Life Span and works awage (Wednesdays from -A treatment plan date demonstrate that she steps to take during wat least one time per prompt 100% of the time months, will engage in exercise with 1 or less week 100% of the time months, will practice skills in the community.	the facility after work If facility at 11:40am with If was sorry and that she was It things since the facility is If making the clients sloppy If was pleasant with the clients. If client #1's record If 6/9/98 If 6/9/98 If facility Loss and If facility If grain Loss and If facility If grain Loss and If grain Loss	V 290			
	time for 12 consecutive	verbal prompt 100% of the ve months, will refrain from				
	, , ,	when in the community with ompts for 12 consecutive				

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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	
		MHL034-413	B. WING		10/2	3/2024
MONARCH DBA UMAR-WADDELL 1323 REY			DRESS, CITY, STANOLDA ROAD -SALEM, NC 2			
(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 SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
V 290	time per a day with 2 12 consecutive month -Unsupervised Time in Assessment dated 5/2 documentation of the "recommendations/re Unsupervised Time at "As needed" -No documentation of unsupervised time in Review on 10/22/24 or revealed: -An admission date or -Diagnosis of Down S Arthritis -Age 43 -An assessment date stature and walks slow arthritis, there are no medical issues do apple activities involving gro such as tying shoes, in judgement and under harm her indicate sup when sleeping, encou Arts, continue to encou look up meanings of viscore of 62." -No documentation of unsupervised time in Review on 10/22/24 or revealed: -An admission date or -Diagnoses of Chronic Developmental Disord	ealthy snack at least one or less verbal prompts for its." In the Community 29/20 noted no strictions/stipulations for it Home". Follow up needed: If the client's ability to have the home or community of client #2's record If 10/22/01 syndrome and Rheumatoid If 3/12/01 noted "is short in why and cautiously due to noted behavioral issues, bear to curtail or limit iss and fine motor skills running, jumping, poor standing of those that may be rivision at all times except urage participating in the burage her desire to read, to works, and has a full IQ If the client's ability to have the home or community If client #3's record If 7/11/13 It Anxiety, Pervasive	V 290			

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Bladder

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER H DBA UMAR-WADDELL	1323 REY	DRESS, CITY, STA NOLDA ROAD -SALEM, NC 2			
(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 SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
V 290	neglect in a Romania years old, her family is the Enrichment Center not need assistance was social, a hard worker loves to go to Starbud support, transportation socialization and long are getting older, and scheduling appointment combing and brushing wardrobe maintenance skills, doesn't comprese things and will topic." -An unsupervised associated "can be left alooneeds assistance with anxiety and how to has should keep her phore contact she is able to -No documentation of unsupervised time in Interview on 10/22/24 Stated she could starthours. I watch to in he bedroom." Interview on 10/22/24 - "I get 8 hours of unsupervised results and the property of the prope	d 7/11/13 noted "post ome due to abuse and norphanage until nearly 4 is actively involved, attends or and has a job coach, does with personal care, is very and always has a smile, oks, needs employment in, group support, it term plan as her parents only needs reminders with only needs reminders with only needs reminders with only needs to learn safety hend spending limits, will sometimes fixate on a sessment dated 7/30/20 one for up to 8 hours but in money, meals, cooking, andle emergencies and the with her and leave a reach." If the client's ability to have the home or community with client #1 revealed: by at the home alone "for 8 ere (living room) or in my with client #2 revealed: pervised time in the home	V 290			

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themselves too."

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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V 290	Continued From page	e 8	V 290			
	-Certain individuals in unsupervised timeClient #1 had up to 8 in the homeClient #2 had 2 hour homeClient #3 had 8 hour home and the community"[Client #3] worked a from 9am to 1pm or 8 in the community. Interview on 10/22/24 Operations revealed:	s hours of unsupervised time s of unsupervised time in the s of unsupervised time in the unity and her hours are usually am to 1:30pm." nated time frames for client pervised time in the home or wised time assessments				

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