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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED			
MHL064-167		B. WING		I	R-C 12/05/2024					
NAME OF	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE									
KOODY HEALTH CARE SERVICES, INC 4 2709 GARY ROAD ROCKY MOUNT, NC 27803										
(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 COMMENT	ΓS		V 000						
	A complaint and fol on December 5, 20 unsubstantiated (In deficiency was cited	24. The complaint take #NC00224188d.	was B). A							
	This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disability.									
	This facility is licens census of 3. The su audits of 2 current of	urvey sample consi	sted of							
V 768	27G .0304(d)(4) Non-Client Accommodations 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: (4) In facilities with overnight accommodations for persons other than clients, such accommodations shall be separate from client bedrooms.		V 768							
	This Rule is not me Based on observati interview, the facilit accommodations for were separate from are:	ion, record review a y failed to ensure o or persons other tha	and vernight an clients,							
	Interview on 12/3/2- The staff slept	4 client #2 reported in the empty client l								

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

TITLE (X6) DATE

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AND DIAN OF CODDECTION INDENTIFICATION NUMBER	LTIPLE CONSTRUCTION DING:	(X3) DATE SURVEY COMPLETED								
A. BOILE		R-C								
MHL064-167 B. WING	S	12/05/2024								
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, C	ITY, STATE, ZIP CODE									
KOODY HEALTH CARE SERVICES, INC 4 2709 GARY ROAD ROCKY MOUNT, NC 27803										
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFI TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG		LD BE COMPLÉTE								
V 768 Interview on 12/3/24 staff #1 reported: Staff worked shifts She worked from 7am to 7pm Didn't spend the night in the facility Didn't know if there was a staff bedroom in the facility Upon further interview with an observation at 9:22am on 12/4/24 staff #1 revealed: An empty bedroom for client accommodation The closet of the empty client bedroom revealed: A robe & clothing items hung on the rack Shoes and a luggage found on the floor She slept in the empty client bedroom or on the couch in the living room The personal items in the client bedroom belonged to her Was told by a former staff that the empty client bedroom was the staff's bedroom Attempted calls and voicemails to staff #2 on 12/4/24 were unsuccessful because staff #2 didn't return any of the phone calls and his mailbox was full. Observation and interview at 4:05pm on 12/3/24 the House Manager reported: Small room adjacent to the living room with a plastic covered mattress that was leaning against the wall The room also had multiple boxes stacked high in the corner The staff slept in the small room adjacent to the living room Staff moved the items out of the room every night The License was still in the progress of fixing	·									

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL064-167			(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		B. WING			R-C 12/05/2024		
	PROVIDER OR SUPPLIER HEALTH CARE SERV	ICES, INC 4	ADDRESS, CITY, S ARY ROAD MOUNT, NC 2				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CON		(X5) COMPLETE DATE	
V 768	Upon further intervi Manager reported: The Qualified F about staff sleeping No progress wa room into a staff's b of Health Services March 2024 During interview on She talked to th sleeping arrangeme Told the Licens empty client bedroo She sent the Li DHSR Construction addressed the lack for staff in the facilit The Licensee ii working on turning bedroom Interview on 12/5/2 Was told by Dh could use the small adjustments were r Was waiting for the facility's landlore	ew on 12/4/24 the House Professional was "on her" In the empty client bedroom as made on making the small bedroom since the last Division Regulation (DHSR) Survey in 12/3/24 the QP reported: The Licensee about staff's ents in the facility ee staff couldn't sleep in the omage of sleeping accommodations by the small room into a staff's 4 the Licensee reported: The	n				

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