STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL080096	A. BUILDING: _____ B. WING _____	C 12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRENTWOOD	609 NEWSOME ROAD SALISBURY, NC 28144

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V 000	INITIAL COMMENTS A complaint survey was completed on 12/4/24. The complaint was substantiated (intake #NC223730). A deficiency was 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 3 and has a current census of 3. The survey sample consisted of audits of 1 current client.	V 000		
V 291	27G .5603 Supervised Living - Operations 10A NCAC 27G .5603 OPERATIONS (a) Capacity. A facility shall serve no more than six clients when the clients have mental illness or developmental disabilities. Any facility licensed on June 15, 2001, and providing services to more than six clients at that time, may continue to provide services at no more than the facility's licensed capacity. (b) Service Coordination. Coordination shall be maintained between the facility operator and the qualified professionals who are responsible for treatment/habilitation or case management. (c) Participation of the Family or Legally Responsible Person. Each client shall be provided the opportunity to maintain an ongoing relationship with her or his family through such means as visits to the facility and visits outside the facility. Reports shall be submitted at least annually to the parent of a minor resident, or the legally responsible person of an adult resident. Reports may be in writing or take the form of a conference and shall focus on the client's progress toward meeting individual goals. (d) Program Activities. Each client shall have activity opportunities based on her/his choices,	V 291	Nurse will inservice QP and Direct Support Supervisor on aftercare regarding all medical procedures. Direct Support Supervisor will inser vice Direct Support Professional regarding aftercare procedures.	

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V 291	Continued From page 1 needs and the treatment/habilitation plan. Activities shall be designed to foster community inclusion. Choices may be limited when the court or legal system is involved or when health or safety issues become a primary concern. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to coordinate services for 1 of 3 clients (#3). The findings are: Review on 12/4/24 of the "Treatment Plan Consent Form" for client #3 revealed: - Consent form was from client #3's dentist office. - Signed by client #3's Legal Guardian on 7/6/24. - "...Extraction tooth 18 (left lower tooth)..." - "...Extraction tooth 29 (right lower tooth)..." Interview on 12/3/24 with client #3's Legal Guardian revealed: - On 10/22/24 client #3 had a lower jaw tooth pulled by client #3's dentist. - He first learned about client #3's tooth being pulled afterwards. Client #3 told him during a telephone conversation on 10/22/24 that his tooth had been pulled. - After the telephone conversation with client #3, he drove over to the facility. - Staff #1 was working when he arrived and "[staff #1] didn't know anything about his (client #3's) tooth being pulled." - "I asked [staff #1] if he had been given any paperwork and [staff #1] said, 'no he didn't get any paperwork.' " - Staff #1 also told him he did not know that client #3's tooth had been pulled.	V 291		

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V 291	Continued From page 2 Interview on 12/4/24 with client #3's dental staff revealed: - Post-operative instructions for client #3's tooth extraction were provided to the Facility Registered Nurse and the Facility Nurse signed the post-operative instructions. Review on 12/4/24 of the "Post-operative Instructions for Extractions" revealed: - "Patient: [client #3] date: 10/22/24" - Please follow these instructions carefully to aid in healing and recovery. - A small amount of oozing is to be expected and may appear greater when mixed with saliva. If the extraction site continues to ooze, apply a wet tea bag with pressure. If there are concerns that there may be excessive bleeding call [client #3's dentist and phone number]. - A mentally impaired resident should never be left unattended with gauze in their mouth. - Be sure that the be sure that the patient gets the pain gets the pain medication that is prescribed before. the anesthesia wears off. Some pain after the extraction. is common. The onset of pain after 3 days or foul smelling mouth may indicate a.'dry socket' If this happens call... - After the surgery, to reduce welling, place a covered ice pack on for 10 minutes and take off for 10 minutes for 2-3 hours after the surgery. Swelling, restricted jaw movement, and bruising can occur and will be the greatest on the second postoperative day. - Wait until the anesthesia has worn off before allowing the resident to either eat or drink. The resident should drink plenty of fluids but avoid extremely hot or cold liquids. The resident may eat whatever he or she can comfortably tolerate. Start with soft foods. - If the resident usually smokes, he or she should refrain from smoking or reduce smoking for the	V 291		

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first twenty-four hours. Smokers have a higher incidence of 'dry sockets.'
- The staff should be sure the mouth is cleaned on a daily basis following surgery. Gently clean the extraction site. The rest of the teeth should be cleaned as usual. A site that is not kept clean does not have the chance to heal.
- Use standing order for pain medication.
- Extractions were done on the: lower left side.
- Total number of teeth extracted: 1
- Facility staff receiving post operative Instructions:[Signature of the Facility Registered Nurse]."

Interview on 12/4/24 with the Facility Registered Nurse revealed:
- She knew that client #3 had his tooth pulled on 10/22/24 because his dentist's office did the extraction at the RHA Health Services NC, LLC Day Program building.
- The dentist's office receptionist prior to 10/22/24 had sent her a list of patients who were going to be seen on 10/22/24 and client #3 was on the list.
- Staff #6 was present with client #3 when he got his tooth pulled.
- She provided no written post-operative information to staff because client #3's dentist did not provide this written information to her .
- She told staff #6 that client #3 could not drink through a straw for the next 5 days and that if he had any pain to call her.
- None of the facility staff contacted her about client #3's tooth being pulled. "I would have had the on-call phone on that day (10/22/24)." None of the other facility nurses were called by the facility staff.

Review on 12/3/24 of client #3's Day Program Sign in Sheet dated 10/22/24 revealed:
- "10/22/24 [client #3] 1:14 pm [staff #6]"

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V 291	Continued From page 4 - "10/22/24 [client #3] 1:46 pm [staff #6]" Interview on 12/3/24 of client #3's Day Program Qualified Professional revealed: - On 10/22/24 staff #6 dropped off client #3 at his day program. - Staff #6 signed him in around "1:00" (pm) (see above). - "When [staff #6] dropped [client #3] off (on 10/22/24), [staff #6] signed him in and [a male consumer who worked at client #3's day program facility] called to the back and told [client #3's day program staff], [client #3] was here and coming to the back." - Staff #6 did not tell any staff at client #3's day program that client #3 was returning from a dental appointment and had his tooth pulled. - She never talked to staff #6 and as she walked down the day program hallway client #3 was throwing up in the trash can. - She tried to call someone at the RHA Health Services NC, LLC Day Program office to come pick up client #3 after he threw up. She was unable to get in contact with anyone at the office. - She had staff #2 who worked for both RHA Health Services NC, LLC and their day program contact the house manager (name unknown) to come pick up client #3. - Staff #6 then returned to client #3's day program and picked up client #3 soon after she had dropped him off (see above). - She did not know client #3 had a tooth pulled until client #3's Legal Guardian called her on 10/24/24 and informed her client #3 had his tooth pulled on 10/22/24. - In addition to not knowing that client #3 had his tooth pulled on 10/22/24, she was not provided with any post-operative instructions for client #3. - "I thought it was weird they (staff #6) dropped [client #3] off super late and the fact that he was	V 291		

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V 291	Continued From page 5 sick." Interview on 12/3/24 with client #3 revealed: - On 10/22/24 staff #6 took him to the RHA Health Services NC, LLC Day Program building to have his tooth pulled and then staff #6 drove him to his day program. - His left lower tooth was pulled. Then staff #6 drove him to his day program. - Denied that staff #6 told any of the staff at his day program that he just had his tooth pulled. - "[Staff #6] signed me in and she go back to the group home." - When he was at his day program, he threw up blood after he ate some of his lunch. - His tooth hurt while he was at his day program and he was not provided any medication for the pain. - His Legal Guardian was not told his tooth had been pulled. - Later staff #6 picked him up at his day program and drove him back to his facility. - When staff #6 brought him back to his facility staff #1 worked the next shift. - Staff #6 did not tell staff #1 that he had his tooth pulled. Interview on 12/4/24 with staff #1 revealed: - He learned about client #3's tooth being pulled when "[client #3] came to me and told me." (10/22/24) - Client #3 also told him that his Legal Guardian did not know about his tooth being pulled. - When client #3 had a telephone conversation with his Legal Guardian on 10/22/24 he told his Legal Guardian that his tooth had been pulled. - Client #3 handed him the phone and he talked to client #3's Legal Guardian. "[Client #3's Legal Guardian] said he was going to call the [RHA Health Services NC, LLC Day Program] and ask	V 291		

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why [client #3] got his tooth pulled and he didn't know anything about it . [Client #3's Legal Guardian] was Just like I was when I found out about [client #3's] tooth being pulled. I was in shock."
- He thought it was staff #6 who brought client #3 back to the facility after his tooth was pulled.
- "[Staff #6] didn't say anything to him about [client #3's] tooth being pulled."
- He also did not know that client #3 got sick on his stomach at client #3's day program.
- He had not been provided with any written post-operative instructions on 10/22/24.
- After client #3, told him his tooth had been pulled he contacted a facility nurse (did not know nurse's name). The nurse told him to keep client #3's mouth clean and to use mouth wash. The nurse told him to call her if client #3 had pain/discomfort or was nausea.
- He worked from 3 pm - 11 pm on 10/22/24 and then staff #6 worked after him.
- On 10/22/24 he wrote in his "blue notes" that he talked to the nurse.

Review on 12/4/24 of staff #1's "2nd shift Blue Notes" revealed:
- "Reported on: 10/22/24 at 8:23 pm"
- There was no documentation that staff #1 talked to a nurse about client #3's tooth being pulled.

Interview on 12/4/24 with staff #3 revealed:
- On 10/22/24 she would have "probably" come on shift at 11 pm.
- She did not know until 12/4/24 that client #3's tooth had been pulled on 10/22/24.
- "[client #3] told me about it (tooth being pulled) today."

Interview on 12/4/24 with staff #6 revealed:
- She took client #3 on 10/22/24 to have his tooth

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V 291	Continued From page 7 pulled at the RHA Health Services NC, LLC Day Program building. - She had been told by client #3's dentist not to allow client #3 to drink out of a straw. "I forgot how long." - She was provided with no other post-operative instructions. She was provided "only verbal instructions about not drinking out of a straw." - After client #3 had his tooth pulled, she drove him to client #3's day program. - When she dropped off client #3 at his day program, she told "a female consumer" who worked there that client #3 was not supposed to drink out of a straw. - "Then right after I dropped [client #3] off like 20 minutes later" the staff at client #3's day program called and told her she needed to pick him up because client #3 had vomited. - After she picked up client #3 at his day program she took him back to his facility. She stayed with client #3 until the next shift staff, staff #1, started to work. - When staff #1 came to work she told him that client #3 had thrown up at his day program. She did not provide staff #1 with any other information. Interview on 12/4/24 with the Administrator/Acting Qualified Professional revealed: - The post-operative instructions that would have been provided to client #3's staff would have come from "the nurse." - She did not know what staff worked on 10/22/24. - The only concern she heard about client #3's tooth being pulled was from client #3's Legal Guardian who told her on the phone he did not know client #3's tooth was pulled on 10/22/24.	V 291		