STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL020-079	A. BUILDING: _____ B. WING _____	06/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE RISIN'	201 HAMPTON CHURCH ROAD MURPHY, NC 28906

(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 6/6/18. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Individuals of all Disability Groups.	V 000		
V 114	27G .0207 Emergency Plans and Supplies 10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES (a) A written fire plan for each facility and area-wide disaster plan shall be developed and shall be approved by the appropriate local authority. (b) The plan 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 fire emergencies. (d) Each facility shall have basic first aid supplies accessible for use. This Rule is not met as evidenced by: Based on record review and interview the facility failed to conduct disaster drills quarterly on each shift. The findings are: Review on 6/6/18 of the facility disaster drills revealed: -No documentation for the A drill, Sunday 4 pm-Wed 8am for the 3rd quarter of 2017. -No documentation for the B drill, Wednesday 8am-Friday 4pm for the 3rd quarter of 2017.	V 114		

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V 114	Continued From page 1 Interview on 6/5/18 with Client's #1, 2, and 3 revealed: -The facility conducted tornado drills. -When a tornado drill was conduct the process was to go in the bathroom and cover your head. Interview on 6/6/18 with the Operations Manager revealed: -The facility had 3 tour shifts, designated as A, B and C. -He was aware of the requirement to do drills on each shift. -The staff failed to perform the drill as required.	V 114		
V 521	27E .0104(e9) Client Rights - Sec. Rest. & ITO 10A NCAC 27E .0104 SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT AND PROTECTIVE DEVICES USED FOR BEHAVIORAL CONTROL (e) Within a facility where restrictive interventions may be used, the policy and procedures shall be in accordance with the following provisions: (9) Whenever a restrictive intervention is utilized, documentation shall be made in the client record to include, at a minimum: (A) notation of the client's physical and psychological well-being; (B) notation of the frequency, intensity and duration of the behavior which led to the intervention, and any precipitating circumstance contributing to the onset of the behavior; (C) the rationale for the use of the intervention, the positive or less restrictive interventions considered and used and the inadequacy of less restrictive intervention techniques that were used; (D) a description of the intervention and the date, time and duration of its use; (E) a description of accompanying positive	V 521		

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V 521	Continued From page 2 methods of intervention; (F) a description of the debriefing and planning with the client and the legally responsible person, if applicable, for the emergency use of seclusion, physical restraint or isolation time-out to eliminate or reduce the probability of the future use of restrictive interventions; (G) a description of the debriefing and planning with the client and the legally responsible person, if applicable, for the planned use of seclusion, physical restraint or isolation time-out, if determined to be clinically necessary; and (H) signature and title of the facility employee who initiated, and of the employee who further authorized, the use of the intervention. This Rule is not met as evidenced by: Based on record review and staff interview the facility failed to ensure the minimum required documentation was completed for the use of a restrictive intervention for 1 of 3 sampled clients (#1). The findings are: Review on 6/6/18 of the facility incident reports revealed: -Incident occurred on 3/8/18 which involved Client #1 - "Staff heard scuffling outside. Staff went out to find ... [Client #1] and another resident squared up trading punches. Staff told ... [Client #1] and the other resident to stop, they did not. ... [Client #1] and the other resident went to the ground still fighting. Staff then had to restrain ... [Client #1] to keep him from beating the other resident ...." -Level II incident report was completed on 3/9/18 for the above listed restraint, but identified only as aggressive behavior with police contact. -No documentation of the type of restraint, duration, positive and less restrictive alternatives	V 521		

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V 521	Continued From page 3 or debriefing. Interview on 6/6/18 with Staff #3 revealed: -Staff #3 was present when the incident occurred with Client #1 on 3/8/18. -Staff #3 initiated a restraint to ensure the safety of the two individuals involved in the altercation. -He completed the level 1 incident report which indicated he had restrained Client #1. Interview on 6/6/18 with the Operations Manager revealed: -He was aware of the altercation between Client #1 and another resident. -He was not aware a restraint had been utilized during the incident. -Staff #3 informed him they had been separated during the incident and did not inform him of the use of a restraint. Interview on 6/6/18 with the Director of Operational Support revealed: -She supervised the staff who was responsible for completion of the Level II reports. -The staff should have questioned the information on the Level I report. -The staff should have obtained all the required documentation for a restraint.	V 521		