Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: B. WING MHL078-283 07/16/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 661 BURNS ROAD RHCC RECOVERY HOME LUMBERTON, NC 28358 SUMMARY STATEMENT OF DEFICIENCIES (X5) . COMPLETE PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) **INITIAL COMMENTS** V 000 An annual survey was completed on July 16, 2018. Deficiencies were cited. **DHSR** - Mental Health This facility is licensed for the following service category: 10A NCAC 27G 5600E Supervised Living for Adults with Substance Abuse Disorders. AUG 302018 V 108 27G .0202 (F-I) Personnel Requirements V 108 Lic. & Cert. Section 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 (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. (i) The governing body shall develop and implement policies and procedures for identifying, reporting, investigating and controlling infectious and communicable diseases of personnel and

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

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1		(X3) DATE SURVEY COMPLETED	
		A. BUILDING:			
	MHL078-283	B. WING		07/1	6/2018
ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STAT	TE, ZIP CODE		
COVERY HOME	661 BURN	IS ROAD			
	LUMBER	TON, NC 28358			·
(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD	BE.	(X5) COMPLETE DATE
Continued From page	: 1	V 108			
clients.					
Based on record reviefacility failed to provid training for two of three the Licensed Clinical affindings are:  Review on 07/13/18 or revealed:  - 37 year old male.  - Admission date of 0° - Diagnoses of Diabet Gastroesophageal Repersion, Anxiety, Insomnia.  Review on 07/13/18 or revealed:  -Hire date: 08/15/16.  -No documentation of training.  Review on 07/13/18 or record revealed:  -Hire date: 01/03/12.  -No documentation of training.  Interview on 07/13/18 or record revealed:  -Hire date: 01/03/12.  -No documentation of training.	ew and interviews, the de diabetes management de audited staff (staff #5 and Addiction Specialist #1). The of client #6's record  7/06/18. des Mellitus, Hypertension, efflux Disease(GERD), Polysubstance Abuse, and of staff #5's personnel record  of the LCAS #1's personnel f Diabetes Management  of the LCAS #1's personnel f Staff #5 stated: de facility for since 2016. de training on Diabetes		for all staff has been so for 9/4/18 to meet this requirement. RHCC Me staff will provide the training. Program Direc Facility Manager will m	cheduled edical ctor and onitor	9/4/18
Interview on 07/13/18	the LCAS #1 stated:				
	COVERY HOME  SUMMARY STA (EACH DEFICIENCY REGULATORY OR LE  Continued From page clients.  Continued From page clients.  This Rule is not met a Based on record reviet facility failed to provide training for two of three the Licensed Clinical and findings are:  Review on 07/13/18 or revealed:  - 37 year old male.  - Admission date of 0 or Diagnoses of Diaber Gastroesophageal Repersion, Anxiety, Insomnia.  Review on 07/13/18 or revealed:  - Hire date: 08/15/16.  - No documentation of training.  Review on 07/13/18 or record revealed:  - Hire date: 01/03/12.  - No documentation of training.  Interview on 07/13/18 or record revealed:  - Hire date: 01/03/12.  - No documentation of training.  Interview on 07/13/18  - He had worked at the had not received Management.	ROVIDER OR SUPPLIER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 1 clients.  This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to provide diabetes management training for two of three audited staff (staff #5 and the Licensed Clinical Addiction Specialist #1). The findings are:  Review on 07/13/18 of client #6's record revealed: - 37 year old male Admission date of 07/06/18 Diagnoses of Diabetes Mellitus, Hypertension, Gastroesophageal Reflux Disease(GERD), Depression, Anxiety, Polysubstance Abuse, and Insomnia.  Review on 07/13/18 of staff #5's personnel record revealed: - Hire date: 08/15/16 No documentation of Diabetes Management training.  Review on 07/13/18 of the LCAS #1's personnel record revealed: - Hire date: 01/03/12 No documentation of Diabetes Management training.  Interview on 07/13/18 staff #5 stated: - He had worked at the facility for since 2016 He had not received training on Diabetes	ROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATEMENT OF DEFICIENCIES  SUMMARY STATEMENT OF DEFICIENCIES  SUMMARY STATEMENT OF DEFICIENCIES  SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 1  clients.  This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to provide diabetes management training for two of three audited staff (staff #5 and the Licensed Clinical Addiction Specialist #1). The findings are:  Review on 07/13/18 of client #6's record revealed:  - 37 year old male.  - Admission date of 07/06/18.  - Diagnoses of Diabetes Mellitus, Hypertension, Gastroesophageal Reflux Disease(GERD), Depression, Anxiety, Polysubstance Abuse, and Insomnia.  Review on 07/13/18 of staff #5's personnel record revealed:  - Hire date: 08/15/16.  - No documentation of Diabetes Management training.  Review on 07/13/18 staff #5 stated:  - He had worked at the facility for since 2016.  - He had worked at the facility for since 2016.  - He had worked at the facility for since 2016.  - He had worked at the facility for since 2016.  - He had not received training on Diabetes Management.	MHL078-283  MHL078-283  MHL078-283  MHL078-283  MHL078-283  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 1  clients.  Pertaining to V 108  Clients.  Pertaining to V 108  Diabetes management training for two of three audited staff (staff #5 and the Licensed Clinical Addiction Specialist #1). The findings are:  Review on 07/13/18 of client #6's record revealed:  -37 year old maleAdmission date of 07/06/18Diagnoses of Diabetes Mellitus, Hypertension, Gastroesophageal Reflux Disease(CERD), Depression, Anxiety, Polysubstance Abuse, and Insomnia.  Review on 07/13/18 of staff #5's personnel record revealed: -Hire date: 08/15/16No documentation of Diabetes Management training.  Review on 07/13/18 staff #5 stated: -Hire date: 01/03/12No documentation of Diabetes Management training.  Interview on 07/13/18 staff #5 stated: -He had worked at the facility for since 2016He had not received training on Diabetes Management.  MHL078-283  STATE TADDRESS, CTY, \$TATE, ZIP CODE 661 BURNS ROAD  LUMBERTON, NC 28358  SUMMARY STATEMENT OF DEFICIENCY)  PREFIX TAG  PROVIDER'S PLAN OF CORRECTION SHOULD CROSS-REPERCIVED CROSS-REPRENCED TO THE APPROPRIES.  (EACH CORRECTIVE ACTION SHOULD CROSS-REPRENCED TO THE APPROPRIES.  Pertaining to V 108  Diabetes management for all staff has been so for 9/4/18 to meet this requirement. RHCC Ms staff will provide the training. Program Direc Facility Management training.  Review on 07/13/18 of staff #5's personnel record revealed: -Hire date: 08/15/16No documentation of Diabetes Management training.  Interview on 07/13/18 staff #5 stated: -He had worked at the facility for since 2016He had not received training on Diabetes Management.  He had not received training on Diabetes Management.	## A BUILDING:

PRINTED: 07/20/2018 FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: \_ B. WING MHL078-283 07/16/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 661 BURNS ROAD RHCC RECOVERY HOME LUMBERTON, NC 28358 SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) V 108 Continued From page 2 V 108 -He had worked at the facility for over a year and had worked for the company in different positions. -He had not received training on Diabetes Management. Interview on 07/13/18 the Program Director/LCAS #2 stated - He would ensure all staff receive training in Diabetes Management. V 118 27G .0209 (C) Medication Requirements V 118 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;

Division of Health Service Regulation

(D) date and time the drug is administered; and (E) name or initials of person administering the

(5) Client requests for medication changes or

PRINTED: 07/20/2018 FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_ MHL078-283 B. WING 07/16/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 661 BURNS ROAD RHCC RECOVERY HOME LUMBERTON, NC 28358 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) V 118 Continued From page 3 V 118 checks shall be recorded and kept with the MAR file followed up by appointment or consultation with a physician. Pertaining to V 118 This Rule is not met as evidenced by: No supplemental substances will be Based on record reviews, observation and interviews, the facility failed to obtain the written allowed at the facility unless ordered 7/17/18 order of a physician to administer and/or failed to by a Doctor and if ordered will be obtain self-administer orders for client monitored, stored in a locked space medications and failed to keep the MARs current and documented in the MAR. Facility affecting two of three clients (#1 and #7). The Manager will monitor DR. orders, findings are: MAR and storage of medications. Finding #1: Review on 07/13/18 of client #1's record revealed: - 57 year old male. - Admission date of 06/06/18. - Diagnoses of Pre-Diabetic, Alcohol Abuse Disorder, Cocaine Abuse Disorder, Knee Pain and Hypertension. Observation on 07/13/18 at approximately 10:50am of client #1's bedroom revealed: - 1 large container of CO-Q Max Daily with Resverotiol. - Bio-Muscle XR 1 large container (dietary/vitamin supplement). - GNC Drinking Container contained approximately 20-32 ounces 1/2 full of unknown

powder substance.

(dietary/vitamin supplement).

(dietary/vitamin supplement).

- Whey Protein 1 large Container, 1/2 full

- Super B Complex 140 tablets, 1/2 full bottle

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
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KHOC KE	COVERT HOME	LUMBER	TON, NC 28358			
(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 CORRECTIC (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETE DATE
V 118	Continued From page	<b>4</b>	V 118			
	orders revealed: - No order for CO-Q N (dietary/vitamin suppl - No order for Whey F supplement) No order for Super E supplement).  Review on 07/13/18 of July/2018 MAR's reverse for CO-Q Max Daily we Protein and Super B of the North Protein and Super B of the No	Protein (dietary/vitamin  B Complex (dietary/vitamin  of client #1's June/2018 and ealed no transcribed entries vith Resverotiol, Whey Complex.				
	and Adjustment Disor Observation on 07/13 11:50am of client #7's - Whey Protein 1 larg - Creatin Powder 1 la container.  Review on 07/13/18 o orders revealed: - No order for Whey F 1/2 full (dietary/vitami - No order for Creatin	5/16/18. ne Severe Abuse Disorder der with Depressed Mood. l/18 at approximately be bedroom revealed: e Container, 1/2 full. rge and 1 medium of client #7's physician				

PRINTED: 07/20/2018 FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED. A. BUILDING: MHL078-283 B. WING 07/16/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 661 BURNS ROAD RHCC RECOVERY HOME LUMBERTON, NC 28358 (X5) COMPLETE DATE (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) V 118 Continued From page 5 V 118 Review on 07/13/18 of client #7's May/2018, June/2018 and July/2018 MAR's revealed no transcribed entries for Whey Protein and Creatin Powder. Interview on 07/13/18 client #7 stated: - He had recently been admitted to the facility. - He had begun using the above dietary/vitamin supplement medications daily and working out at a local gym. Interview on 07/13/18 the Facility Manager stated: - He was not aware the clients could not have the dietary supplements unsecured in their room. - He did not have medical orders for client #1 and client #7's dietary supplements. - He would follow up to ensure the MARs were current and the orders were obtained for all client medications, and for all medications to be maintained in a secure sett. Due to the failure to accurately document medication administration it could not be determined if clients received their medications as ordered by the physician. V 120 27G .0209 (E) Medication Requirements V 120

Division of Health Service Regulation

10A NCAC 27G .0209 MEDICATION

(1) All medication shall be stored:(A) in a securely locked cabinet in a clean, well-lighted, ventilated room between 59 degrees

(B) in a refrigerator, if required, between 36 degrees and 46 degrees Fahrenheit. If the refrigerator is used for food items, medications

and 86 degrees Fahrenheit;

REQUIREMENTS
(e) Medication Storage:

FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_ MHL078-283 B. WING 07/16/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 661 BURNS ROAD RHCC RECOVERY HOME LUMBERTON, NC 28358 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DAT'E TAG DEFICIENCY) V 120 Continued From page 6 V 120 shall be kept in a separate, locked compartment or container; (C) separately for each client; (D) separately for external and internal use; (E) in a secure manner if approved by a physician for a client to self-medicate. (2) Each facility that maintains stocks of controlled substances shall be currently registered under the North Carolina Controlled Substances Act, G.S. 90, Article 5, including any subsequent amendments. This Rule is not met as evidenced by: Based on observation and interview the facility failed to store medications in a securely locked cabinet or container. The findings are: Finding #1: Review on 07/13/18 of client #1's record revealed: - 57 year old male. - Admission date of 06/06/18. - Diagnoses of Pre-Diabetic, Alcohol Abuse Disorder, Cocaine Abuse Disorder, Knee Pain and Hypertension. Observation on 07/13/18 at approximately 10:50am of client #1's bedroom revealed: - 1 large container of CO-Q Max Daily with Resverotiol. - Bio-Muscle XR 1 large container (dietary/vitamin supplement). - GNC Drinking Container contained approximately 20-32 ounces 1/2 full of unknown powder substance. - Whey Protein 1 large Container, 1/2 full

Division of Health Service Regulation

(dietary/vitamin supplement).

- Super B Complex 140 tablets, 1/2 full bottle

FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED A. BUILDING: \_ B. WING\_ MHL078-283 07/16/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 661 BURNS ROAD RHCC RECOVERY HOME LUMBERTON, NC 28358 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ın PROVIDER'S PLAN OF CORRECTION

(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 120	Continued From page 7 (dietary/vitamin supplement).	V 120	,		
	Finding #2: Review on 07/13/18 of client #7's record revealed: - 47 year old male Admission date of 05/16/18 Diagnoses of Cocaine Severe Abuse Disorder and Adjustment Disorder with Depressed Mood.  Observation on 07/13/18 at approximately 11:50am of client #7's bedroom revealed: - Whey Protein 1 large Container, 1/2 full Creatin Powder 1 large and 1 medium container.				
	Interview on 07/13/18 the Facility Manager stated:  - He was not aware the clients could not have the dietary supplements unsecured in their room.  - He would follow up to ensure all client medications would be maintained and secured immediately.				
V 536	27E .0107 Client Rights - Training on Alt to Rest. Int.  10A NCAC 27E .0107 TRAINING ON ALTERNATIVES TO RESTRICTIVE INTERVENTIONS  (a) Facilities shall implement policies and practices that emphasize the use of alternatives to restrictive interventions.  (b) Prior to providing services to people with disabilities, staff including service providers, employees, students or volunteers, shall demonstrate competence by successfully completing training in communication skills and other strategies for creating an environment in	V 536			

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		
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NAME OF PI	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
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V 536	Continued From page	e 8	V 536			
V 536	which the likelihood o or injury to a person was property damage is property damage and demograthered.  (d) The training shall limiculate measurable testing (was behavior) on those observation on those observation in the determinent of the d	fimminent danger of abuse with disabilities or others or revented. Is shall establish training etencies, monitor for internal constrate they acted on data the competency-based, earning objectives, written and by observation of objectives and measurable as passing or failing the training must be completed der periodically (minimum ming that the service apploy must be approved by D/SAS pursuant to Rule.  Strate competence in the and understanding of the and interpreting human the effect of internal and at may affect people with the importance of and in's involvement in making	V 536			
	escalating behavior;					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN (	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
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14100112	JOVEN HOME	LUMBERTO	ON, NC 28358			
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V 536	Continued From page	9	V 536			
V 530	(8) communica and de-escalating por and (9) positive behinder means for people with activities which direct behaviors which are used (h) Service providers documentation of initiat least three years.  (1) Documenta (A) who particip outcomes (pass/fail); (B) when and with the control of the distribution of the control of	tion strategies for defusing tentially dangerous behavior; navioral supports (providing h disabilities to choose ly oppose or replace unsafe). Is shall maintain fall and refresher training for tion shall include: nated in the training and the where they attended; and name; nof MH/DD/SAS may be cumentation at any time. The attended to the training and the sations and Training and the sations and training program reducing and eliminating the	V 536			
	by scoring a passing instructor training pro (3) The training competency-based, in objectives, measurable observation of behavimeasurable methods failing the course. (4) The content service provider plans approved by the Divis to Subparagraph (i) (5) Acceptable shall include but are re-	grade on testing in an gram. g shall be include measurable learning le testing (written and by lior) on those objectives and to determine passing or  t of the instructor training the s to employ shall be sion of MH/DD/SAS pursuant				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		MHL078-283	B. WING		07/1	6/2018
NAME OF P	ROVIDER OR SUPPLIER		RESS, CITY, STA	TE, ZIP CODE		•
RHCC RE	COVERY HOME	661 BURNS LUMBERTO	N, NC 28358			
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V 536	course; (C) methods for performance; and (D) documentati (6) Trainers shateaching a training properties of the coach. (T) Trainers shateaching and elimination interventions at least review by the coach. (T) Trainers shateaimed at preventing, in need for restrictive information annually. (B) Trainers shateaimed at preventing at least training for at least the course (pass/fail); (B) when and work (C) instructor's (C) The Division request and review the course which is better the course which is the course which is the course which is the course which is th	r teaching content of the r evaluating trainee ion procedures. all have coached experience ogram aimed at preventing, ing the need for restrictive one time, with positive all teach a training program reducing and eliminating the terventions at least once all complete a refresher east every two years. shall maintain al and refresher instructor ree years. entation shall include: ated in the training and the where attended; and name. of MH/DD/SAS may is documentation any time. Coaches: all meet all preparation iner. all teach at least three times eing coached. all demonstrate letion of coaching or	V 536	DEFICIENCY		
	(I) Documentation sh	all be the same preparation				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE S COMPLI	
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		MHL078-283	B. WING		07/1	6/2018
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V 536	Continued From page This Rule is not met a	as evidenced by:	·V 536			
	failed to ensure one o (Licensed Clinical Add	diction Specialist #1 (LCAS)) ng updates in alternatives to				
	record revealed: - Date of hire: 06/27/1	of the LCAS #1's personnel 6. In alternatives to restrictive		Pertaining to V 536  LCAS # 1 staff has been	8/7/18	
	interventions.  Interview on 07/13/18  - He had training in al interventions which had	ternatives to restrictive		NCI alternatives to restrictive interventions and all staff currently 8/14/ are trained and up to date. RHCC NCI provider will provide trainings as needed. Program Director and		8/14/18
	Interview on 07/13/18 #2 stated: -He would arrange for scheduled.	the Program Director/LCAS		Facility Manager will mor scheduling of trainings as		
V 537	27E .0108 Client Righ	nts - Training in Sec Rest &	V 537			
	ISOLATION TIME-OL (a) Seclusion, physic time-out may be empl been trained and have competence in the pre to these procedures. staff authorized to em	CAL RESTRAINT AND  JT  al restraint and isolation loyed only by staff who have e demonstrated oper use of and alternatives Facilities shall ensure that uploy and terminate these ned and have demonstrated	·			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X1) PROVIDER/SUPPLIER/SUP		(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		MHL078-283	B. WING		07/	16/2018
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
RHCC R	ECOVERY HOME		TON, NC 28358			
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
V 53	(b) Prior to providing disabilities whose treatincludes restrictive interpretation service providers, emportant volunteers shall composeclusion, physical reand shall not use the training is completed demonstrated.  (c) A pre-requisite for demonstrating competraining in preventing, the need for restrictive (d) The training shall include measurable learnessurable testing (vince) behavior) on those of methods to determine course.  (e) Formal refresher by each service proviannually).  (f) Content of the trait provider plans to empthe Division of MH/DI Paragraph (g) of this (g) Acceptable training but are not limited to, (1) refresher into the use of restrictive in (2) guidelines of (understanding imminothers);  (3) emphasis or rights and dignity of a concepts of least restricting in the use of restrictive in concepts of least restriction in the use of restrictive in the use of restrictive in the use of restrictive in (2) guidelines of (understanding imminothers);	direct care to people with atment/habilitation plan terventions, staff including ployees, students or oblete training in the use of straint and isolation time-out se interventions until the and competence is a taking this training is stence by completion of reducing and eliminating in interventions. The competency-based, earning objectives, written and by observation of objectives and measurable is passing or failing the straining must be completed der periodically (minimum ming that the service obloy must be approved by D/SAS pursuant to Rule.  The programs shall include, presentation of: formation on alternatives to interventions; on when to intervene ment danger to self and an intervention); or the safe implementation or the safe implementation or the safe implementation.	V 537			

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING: COMPLETED			
		MHL078-283	B. WING		07/16/2018
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	ATE, ZIP CODE	
BUCC DE	COVERY HOME	661 BUR	NS ROAD		
KHCC KE	COVERT HOME	LUMBER	TON, NC 28358	· ·	
(X4) ID		ATEMENT OF DEFICIENCIES	DI DI	PROVIDER'S PLAN OF CORRECT	
PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX TAG	(EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRODE DEFICIENCY)	
V 537	Continued From page	: 13	V 537		
	(5) the use of e	mergency safety			
	interventions which in	clude continuous	·		
		itoring of the physical and			
		ing of the client and the safe			
		phout the duration of the			
	restrictive intervention	•			
	(6) prohibited p (7) debriefing s	roceaures; trategies, including their			·
•	importance and purpo	•			
		ion methods/procedures.			
	(h) Service providers			·	
	documentation of initial and refresher training for			·	
	at least three years.	_			
	' '	tion shall include:			
	(A) who particip outcomes (pass/fail);	ated in the training and the			
		here they attended; and			
	(C) instructor's				
		of MH/DD/SAS may			
	•	ocumentation at any time.			
	(i) Instructor Qualificate Requirements:	ation and Training			
	•	all demonstrate competence			
		esting in a training program			
	, ,	reducing and eliminating the			
	need for restrictive int	-			
	(2) Trainers sha	all demonstrate competence			
		esting in a training program			
		eclusion, physical restraint			
	and isolation time-out				
		all demonstrate competence			
	instructor training pro	grade on testing in an			
	(4) The training	_			
		nclude measurable learning			1
		le testing (written and by			
		or) on those objectives and			
		to determine passing or			
	failing the course.				

PRINTED: 07/20/2018 FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_ MHL078-283 B. WING 07/16/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 661 BURNS ROAD RHCC RECOVERY HOME LUMBERTON, NC 28358 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) V 537 Continued From page 14 V 537 The content of the instructor training the service provider plans to employ shall be approved by the Division of MH/DD/SAS pursuant to Subparagraph (j)(6) of this Rule. Acceptable instructor training programs shall include, but not be limited to, presentation of: understanding the adult learner; (A) (B) methods for teaching content of the course; (C) evaluation of trainee performance; and (D) documentation procedures. (7)Trainers shall be retrained at least annually and demonstrate competence in the use of seclusion, physical restraint and isolation time-out, as specified in Paragraph (a) of this Rule. (8) Trainers shall be currently trained in CPR. (9) Trainers shall have coached experience in teaching the use of restrictive interventions at least two times with a positive review by the coach. (10)Trainers shall teach a program on the use of restrictive interventions at least once annually. (11)Trainers shall complete a refresher instructor training at least every two years. (k) Service providers shall maintain documentation of initial and refresher instructor training for at least three years. (1) Documentation shall include:

Division of Health Service Regulation

(A)

(B) (C)

(2)

outcome (pass/fail):

who participated in the training and the

when and where they attended; and

The Division of MH/DD/SAS may review/request this documentation at any time.

instructor's name.

(I) Qualifications of Coaches:

PRINTED: 07/20/2018 FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: MHL078-283 B. WING 07/16/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 661 BURNS ROAD RHCC RECOVERY HOME LUMBERTON, NC 28358 (X5) COMPLETE (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) V 537 Continued From page 15 V 537 Coaches shall meet all preparation (1)requirements as a trainer. Coaches shall teach at least three times, the course which is being coached. Coaches shall demonstrate competence by completion of coaching or train-the-trainer instruction. (m) Documentation shall be the same preparation as for trainers. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure one of three audited staff Pertaining to V 537 (Licensed Clinical Addiction Specialist #1 (LCAS)) received annual training updates in seclusion. LCAS # 1 staff has been trained in 8/7/18 physical restraint and isolation time-out. The NCI seclusion, physical restraint and findings are: isolation time out and all staff are currently trained and up to date. Review on 07/13/18 of the LCAS #1's personnel record revealed: RHCC NCI provider will provide - Date of hire: 06/27/16, trainings as needed. Program Director - Expired training dated 04/28/18 in updates in and Facility Manager will monitor the seclusion, physical restraint and isolation scheduling of trainings as needed. time-out. 8/14/18 Interview on 07/13/18 the LCAS #1 stated: - He had training in alternatives to restrictive interventions which had expired.

scheduled.

Interview on 07/13/18 the Program Director/LCAS

-He would arrange for the training to be