	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
						R
		mhl026-005	B. WING		08/	23/2018
NAME OF F	PROVIDER OR SUPPLIER		ADDRESS, CITY, ST	TATE, ZIP CODE		
MYROVE	R-REESE FELLOWS		ALITY ROAD EVILLE, NC 28	3306		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 000	INITIAL COMMENT	ſS	V 000			
		w up survey was completed . Deficiencies were cited.				
	category: 10A NCA	sed for the following service C 27G .5600E Supervised h Substance Abuse.				
V 108	27G .0202 (F-I) Per	sonnel Requirements	V 108			
	 (g) Employee trainiprovided and, at a r following: (1) general organiz (2) training on clier delineated in 10A N 10A NCAC 26B; 	cation shall be documented. ing programs shall be minimum, shall consist of the cational orientation; it rights and confidentiality as ICAC 27C, 27D, 27E, 27F and				
		t the mh/dd/sa needs of the n the treatment/habilitation tious diseases and				
	bloodborne pathoge (h) Except as perm .5602(b) of this Sub member shall be av times when a client					
	including seizure m to provide cardiopu trained in the Heiml techniques such as the American Heart	anagement, currently trained Imonary resuscitation and lich maneuver or other first aid those provided by Red Cross Association or their	d			
	(i) The governing b implement policies reporting, investiga	eving airway obstruction. ody shall develop and and procedures for identifying ting and controlling infectious diseases of personnel and				

TITLE

Division	of Health Service Re	gulation					
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/S IDENTIFICAT	SUPPLIER/CLIA ION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		mhl026-0	05	B. WING			२ 2 3/2018
NAME OF F	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MYROVE	R-REESE FELLOWS	HIP HOME		.ITY ROAD VILLE, NC 2	8306		
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENCY REGULATORY OR LS		DED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	LD BE	(X5) COMPLETE DATE
V 108	Continued From pa	ge 1		V 108			
	clients.						
	This Rule is not me Based on record re facility failed to ensu Cardiopulmonary R 1 of 3 audited staff Manager). The findi Review on 08/23/18 Manager's personn - Date of Hire on 12 - CPR and First Aid and expired on 11/2 - No documentation training.	views and inter ure First Aid an esuscitation (C (2nd shift Grou ings are: 3 of the 2nd shi el record revea 2/05/15. training docun 2017.	views, the d PR) training for p Home ft Group Home lled: nented 11/21/15				
	Interview on 08/23/ Manager stated: -She worked alone her CPR and First A	on her shift an	d was unaware				
	Interview on 08/23/ stated: -She was in the pro the staff.	-					
V 536	27E .0107 Client Ri Int.	ghts - Training	on Alt to Rest.	V 536			
	10A NCAC 27E .01 ALTERNATIVES TO INTERVENTIONS (a) Facilities shall in practices that emph	D RESTRICTIN	cies and				

	of Health Service Re					
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		mhl026-005	B. WING			R 23/2018
					00/	23/2010
IAME OF I	PROVIDER OR SUPPLIER		ADDRESS, CITY, S	TATE, ZIP CODE		
IYROVE	ER-REESE FELLOWS		ALITY ROAD EVILLE, NC 28	3306		
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	THE APPROPRIATE	COMPLET DATE
V 536	Continued From pa	ige 2	V 536			
	to restrictive interve	entions.				
		ng services to people with				
		luding service providers,				
		ts or volunteers, shall				
		etence by successfully				
		in communication skills and				
		creating an environment in				
		l of imminent danger of abuse	e			
		n with disabilities or others or				
	property damage is	ies shall establish training				
		petencies, monitor for interna	al			
		monstrate they acted on data				
	gathered.					
		all be competency-based,				
		e learning objectives,				
		(written and by observation o	f			
		objectives and measurable				
		ine passing or failing the				
	COURSE.	or training must be completed				
		er training must be completed ovider periodically (minimum				
	annually).	wider periodically (minimum				
		raining that the service				
		employ must be approved by				
		DD/SAS pursuant to				
	Paragraph (g) of thi					
	(g) Staff shall dem	onstrate competence in the				
	following core areas					
		e and understanding of the				
	people being serve					
		ng and interpreting human				
	behavior; (3) recognizir	ng the effect of internal and				
		hat may affect people with				
	disabilities;	hat may anoot people with				
		for building positive				
	(.) Strategiou					
	relationships with p	ersons with disabilities;				

Division	of Health Service Re	aulation			FORM	APPROVED
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		LETED
		mhl026-005	B. WING		F 08/2	२ 3/2018
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MYROVE	R-REESE FELLOWS		LITY ROAD VILLE, NC 2	8306		
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT		(X5)
PREFIX TAG		MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)		COMPLETE DATE
V 536	Continued From pa	ge 3	V 536			
	disabilities; (6) recognizin assisting in the pers decisions about the (7) skills in as escalating behavior (8) communit and de-escalating p and (9) positive be means for people w activities which dire behaviors which are (h) Service provide documentation of in at least three years (1) Documen (A) who partic outcomes (pass/fail (B) when and (C) instructor (2) The Divisi review/request this (i) Instructor Qualif Requirements: (1) Trainers s by scoring 100% on aimed at preventing need for restrictive (2) The trainin competency-based, objectives, measura observation of beha	ssessing individual risk for ; cation strategies for defusing potentially dangerous behavior; ehavioral supports (providing rith disabilities to choose ctly oppose or replace e unsafe). rs shall maintain itial and refresher training for tation shall include: ipated in the training and the); where they attended; and 's name; on of MH/DD/SAS may documentation at any time. ications and Training shall demonstrate competence a testing in a training program g, reducing and eliminating the interventions. shall demonstrate competence g grade on testing in an				
Division of H	ealth Service Regulation		I			I

Division	of Health Service Re	aulation			FORM	APPROVED
STATEME	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMPI	
		mhl026-005	B. WING		R 08/2	3/2018
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
MYDOW		613 QUAL	ITY ROAD			
WITROV	ER-REESE FELLOWS	FAYETTEN	VILLE, NC 2	28306		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
V 536	Continued From pa	ge 4	V 536			
	 (4) The contesservice provider plata approved by the Division of Subparagraph (i) (5) Acceptablic shall include but area (A) understan (B) methods course; (C) methods performance; and (D) document (6) Trainers at leaching a training preducing and elimina interventions at lease review by the coach (7) Trainers at lease review by the coach (7) Trainers at lease instructor training at preventing and elimina interventions at lease instructor training at (j) Service provider documentation of intraining for at least (1) Docurr (A) who partice outcomes (pass/fail (B) when and (C) instructor (2) The Division request and review (k) Qualifications of (1) Coaches at (2) Coaches at (2) Coaches (2) The course which is the	ent of the instructor training the ns to employ shall be vision of MH/DD/SAS pursuant (5) of this Rule. e instructor training programs e not limited to presentation of: ding the adult learner; for teaching content of the for evaluating trainee ation procedures. hall have coached experience orogram aimed at preventing, ating the need for restrictive st one time, with positive hall teach a training program interventions at least once hall complete a refresher t least every two years. s shall maintain itial and refresher instructor three years. nentation shall include: ipated in the training and the); where attended; and 's name. on of MH/DD/SAS may this documentation any time. f Coaches: shall meet all preparation rainer. shall teach at least three times				

Division of Health Service Regulation STATE FORM

STATEMEN	of Health Service Re IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		mhl026-005	B. WING			R 23/2018
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	TATE, ZIP CODE		
MYROVE	R-REESE FELLOWS		LITY ROAD VILLE, NC 28	306		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
V 536	competence by cor train-the-trainer ins	npletion of coaching or	V 536			
	facility failed to ens shift Group Home M training in alternative The findings are: Review on 08/23/18 Manager's personn - Date of Hire on 06 - No documentation restrictive intervent	eviews and interview, the ure 1 of 3 audited staff (1st Manager) received annual ves to restrictive interventions. B of 1st shift Group Home lel record revealed: 5/19/18. n of training in alternatives to				
V 597	the staff.	ocess of arranging training for	V 537			
V 537	ITO 10A NCAC 27E .01 SECLUSION, PHY ISOLATION TIME-((a) Seclusion, phys time-out may be en been trained and ha competence in the	SICAL RESTRAINT AND OUT sical restraint and isolation nployed only by staff who have				

Division of Health Service Regulation STATE FORM

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If continuation sheet 6 of 10

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	TO CORRECTION	IDENTIFICATION NOMBER.	A. BUILDING:		COM	
		mhl026-005	B. WING			R 23/2018
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
MYROVI	ER-REESE FELLOWS	HIP HOME				
			EVILLE, NC 28			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
V 537	Continued From pa	ge 6	V 537			
	procedures are retr competence at lease (b) Prior to providin disabilities whose tr includes restrictive service providers, evolunteers shall con seclusion, physical and shall not use the training is complete demonstrated. (c) A pre-requisite demonstrating com training in preventin the need for restrict (d) The training sha include measurable measurable testing behavior) on those methods to determin course. (e) Formal refreshe by each service pro- annually). (f) Content of the tr provider plans to er the Division of MH// Paragraph (g) of thi (g) Acceptable train but are not limited t (1) refresher the use of restrictive (2) guidelines (understanding imm others); (3) emphasis rights and dignity of	g direct care to people with reatment/habilitation plan interventions, staff including employees, students or mplete training in the use of restraint and isolation time-out lese interventions until the ed and competence is for taking this training is petence by completion of hg, reducing and eliminating tive interventions. All be competency-based, e learning objectives, (written and by observation of objectives and measurable ine passing or failing the er training must be completed ovider periodically (minimum raining that the service mploy must be approved by DD/SAS pursuant to is Rule. ning programs shall include, o, presentation of: information on alternatives to	t			

Division	of Health Service Re	gulation				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE S COMPL	
		mhl026-005	B. WING		R 08/23	3/2018
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MYROW	R-REESE FELLOWS	613 QUAL	ITY ROAD			
WITKOVI		FAYETTE	VILLE, NC 2	8306		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
V 537	Continued From pa	ge 7	V 537			
	incremental steps in (4) strategies of restrictive interver (5) the use of interventions which assessment and mo- psychological well-ture use of restraint thro- restrictive interventi (6) prohibited (7) debriefing importance and pur (8) document (9) document (1) Service provider documentation of in at least three years (1) Documen (A) who partice outcomes (pass/fail (B) when and (C) instructor (2) The Divisi review/request this (i) Instructor Qualific Requirements: (1) Trainers so by scoring 100% or aimed at preventing need for restrictive (2) Trainers so by scoring 100% or teaching the use of and isolation time-of (3) Trainers so by scoring a passin instructor training p (4) The training	h an intervention); for the safe implementation ntions; emergency safety include continuous ponitoring of the physical and being of the client and the safe ughout the duration of the on; procedures; strategies, including their pose; and ation methods/procedures. s shall maintain itial and refresher training for tation shall include: ipated in the training and the); where they attended; and 's name. on of MH/DD/SAS may documentation at any time. ication and Training thall demonstrate competence testing in a training program g, reducing and eliminating the interventions. hall demonstrate competence testing in a training program seclusion, physical restraint ut. hall demonstrate competence g grade on testing in an				

STATEMEN	of Health Service Re NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
	IOI CONNECTION	IDENTIFICATION NOMBER.	A. BUILDING:		COM	
		mhl026-005	B. WING			R 23/2018
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE		
MYROVE	ER-REESE FELLOWS		LITY ROAD	8306		
(X4) ID	SUMMARY STA		ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	THE APPROPRIATE	COMPLET DATE
V 537	Continued From pa	age 8	V 537			
	observation of beha	avior) on those objectives and				
		ds to determine passing or				
	failing the course.	ant of the inclusion training the				
		ent of the instructor training the				
	service provider plans to employ shall be approved by the Division of MH/DD/SAS pursuant		t			
	to Subparagraph (j)(6) of this Rule.					
	(6) Acceptable instructor training programs					
		ot be limited to, presentation				
	of: (A) understan	iding the adult learner;				
	(B) methods for teaching content of the					
	course;	3				
		n of trainee performance; and				
	• •	tation procedures.				
		shall be retrained at least nstrate competence in the use				
		cal restraint and isolation				
		ed in Paragraph (a) of this				
	Rule.					
	CPR.	shall be currently trained in				
		shall have coached experience				
		of restrictive interventions at a positive review by the				
	coach.					
	(10) Trainers	shall teach a program on the				
		terventions at least once				
	annually.	aboll complete e refrecher				
		shall complete a refresher it least every two years.				
	(k) Service provide					
		nitial and refresher instructor				
	training for at least	three years.				
		itation shall include:				
		cipated in the training and the				
	outcome (pass/fail) (B) when and	; d where they attended; and				
	(C) instructor					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED	
	01 001112011011		A. BUILDING:			
		mhl026-005	B. WING			R 23/2018
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
YROVE	R-REESE FELLOWS		ALITY ROAD EVILLE, NC 28	8306		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF	CORRECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLET DATE
V 537	Continued From pa	age 9	V 537			
	review/request this (I) Qualifications of (1) Coaches requirements as a (2) Coaches times, the course w (3) Coaches competence by con train-the-trainer ins	shall meet all preparation trainer. shall teach at least three which is being coached. shall demonstrate mpletion of coaching or truction. n shall be the same				
	Based on record re facility failed to ens received training in	et as evidenced by: eviews and interviews, the ure 1 of 3 audited staff seclusion, physical restraint out (1st shift Group Home lings are:				
	Manager's personn - Date of Hire on 06 - No documentation physical restraint a	6/19/18. n of training in seclusion, nd isolation time-out.				
	stated:	18 the Program Director				