Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _		
		MHL0601227	B. WING		09/28/2018
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE	
MERANCA	AS COTTAGE		T PETERS LAN	NE, SUITE 300	
	OLUMANA DV. OT		/S, NC 28105	DDO//DEDIO DI ANI OF CODDECTIO	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE COMPLETE
V 000	INITIAL COMMENTS	;	V 000		
	A complaint survey w The complaint was su #NC143038). A defic	•			
	_	d for the following service 27G .1900 Psychiatric t Facility.			
V 537	27E .0108 Client RigI	nts - Training in Sec Rest &	V 537		
	ISOLATION TIME-OU  (a) Seclusion, physic time-out may be emp been trained and have competence in the properties of these procedures. Staff authorized to emprocedures are retrained to the procedures whose training to the providers, empored the procedure of	CAL RESTRAINT AND JT cal restraint and isolation doyed only by staff who have de demonstrated oper use of and alternatives Facilities shall ensure that apploy and terminate these and and have demonstrated annually. direct care to people with atment/habilitation plan terventions, staff including apployees, students or oblete training in the use of destraint and isolation time-out se interventions until the and competence is  r taking this training is etence by completion of the reducing and eliminating the interventions.  be competency-based,			

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

TITLE (X6) DATE

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		MHL0601227 B. WING			09/25	3/2018
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE. ZIP CODE	1 09/20	5/2016
MEDANC	AS COTTAGE		T PETERS LAN			
WIERANG	43 COTTAGE	MATTHEW	/S, NC 28105			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
V 537	Continued From page	e 1	V 537			
	methods to determine course.  (e) Formal refresher by each service proviannually).  (f) Content of the train provider plans to empthe Division of MH/DI Paragraph (g) of this (g) Acceptable training but are not limited to, (1) refresher in the use of restrictive in (2) guidelines of (understanding imminothers);  (3) emphasis of rights and dignity of a concepts of least rest incremental steps in a concepts of least rest incremental steps in a concept of least rest incr	training must be completed der periodically (minimum fining that the service ploy must be approved by D/SAS pursuant to Rule.  Ing programs shall include, presentation of: formation on alternatives to interventions; on when to intervene ment danger to self and in safety and respect for the full persons involved (using trictive interventions and an intervention); or the safe implementation tions; emergency safety include continuous pitoring of the physical and sing of the client and the safe ghout the duration of the in; procedures; strategies, including their ose; and tion methods/procedures.				

Division of Health Service Regulation

STATE FORM 6899 P9GC11 If continuation sheet 2 of 8

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COMPLETED	
		MHL0601227	B. WING		09/28/2018
NAME OF D			DESC CITY STA	TE ZID CODE	1 00.20.20.10
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA		
MERANCA	AS COTTAGE		T PETERS LAN	NE, SUITE 300	
		MATTHEW	S, NC 28105		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO  (EACH CORRECTIVE ACTION SHOULD  CROSS-REFERENCED TO THE APPROPI  DEFICIENCY)	BE COMPLETE
V 537	Continued From page	e 2	V 537		
	(C) instructor's				
		n of MH/DD/SAS may			
		ocumentation at any time.			
	(i) Instructor Qualification	ation and Training			
	Requirements:				
	(1) Trainers sha	all demonstrate competence			
	by scoring 100% on t	esting in a training program			
	aimed at preventing,	reducing and eliminating the			
	need for restrictive in	terventions.			
	(2) Trainers sha	all demonstrate competence			
	by scoring 100% on t	esting in a training program			
	teaching the use of se	eclusion, physical restraint			
	and isolation time-out				
		all demonstrate competence			
	` '	grade on testing in an			
	instructor training pro	-			
	(4) The training	-			
		nclude measurable learning			
		le testing (written and by			
		ior) on those objectives and			
		to determine passing or			
	failing the course.	to determine passing or			
	_	t of the instructor training the			
	service provider plans	•			
		sion of MH/DD/SAS pursuant			
	to Subparagraph (j)(6				
	1 1 1	instructor training programs			
		be limited to, presentation			
	of:				
		ng the adult learner;			
	' '	r teaching content of the			
	course;				
		of trainee performance; and			
	` '	ion procedures.			
	` '	all be retrained at least			
	1	strate competence in the use			
	of seclusion, physical	restraint and isolation			
	time-out, as specified	l in Paragraph (a) of this			
	Rule.	<b>.</b> . , ,			

Division of Health Service Regulation

STATE FORM 6899 P9GC11 If continuation sheet 3 of 8

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	
		MHL0601227	B. WING		09/28/2018
			DRESS, CITY, STA	TE ZIP CODE	1 00/20/2010
			NT PETERS LAN		
MERANCA	AS COTTAGE	MATTHEN	VS, NC 28105		
(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 CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
V 537	7 Continued From page 3		V 537		
	(8) Trainers shall cPR. (9) Trainers shall in teaching the use of least two times with a coach. (10) Trainers shall use of restrictive internationally. (11) Trainers shall instructor training at le (k) Service providers documentation of inititatining for at least th (1) Documenta (A) who participoutcome (pass/fail); (B) when and verification of Common commo	all be currently trained in all have coached experience f restrictive interventions at a positive review by the all teach a program on the ventions at least once all complete a refresher east every two years. shall maintain al and refresher instructor ree years. tion shall include: ated in the training and the where they attended; and name. In of MH/DD/SAS may becomentation at any time. coaches: all meet all preparation iner. all teach at least three ch is being coached. all demonstrate eletion of coaching or action. shall be the same			
	facility failed to ensur	riew and interviews, the			

Division of Health Service Regulation

former staff (FS#3). The findings are:

STATE FORM P9GC11 If continuation sheet 4 of 8

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	
			_			
		MHL0601227	B. WING		09/28/2018	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
MERANC	AS COTTAGE		T PETERS LAN S, NC 28105	NE, SUITE 300		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE	
V 537	Continued From page	e 4	V 537			
	-hire date of 4/20/18 (Psychiatric Resident Residential Care Spe -completed training ir -terminated on 9/13/1	ial Treatment Facility)				
	-admission date of 6/3 Disruptive Mood Dysi Attention Deficit Hype	eractivity Disorder, with Disturbance of Conduct				
	9/12/18 documented -FS#3 was in the proofight between client # -FS#3 got a hold of cland client #1's face h	cess of intervening during a 1 and several other clients; lient #1, spun him around				
	9/12/18 documented -client #1 was in kitch nose; -bleeding stopped she -client #1 refused colo -Nurse assessed clied day, no bruising or sy	ortly after Nurse arrived; d pack or pain medication; nt #1's nose later that same				
	revealed the following -client #2 had the bro with it, staff #1 was fo	g: om, was walking around				

Division of Health Service Regulation

STATE FORM 6899 P9GC11 If continuation sheet 5 of 8

PRINTED: 10/09/2018

Division	of Health Service Regu	ılation			FORM	APPROVED	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
	MHL0601227				09/2	09/28/2018	
NAME OF PROVIDER OR SUPPLIER STREET ADD			DDRESS, CITY, STAT	TE, ZIP CODE			
MEDANC	AS COTTAGE	6750 SAI	INT PETERS LAN	IE, SUITE 300			
MERANO	A3 COTTAGE	MATTHE	WS, NC 28105				
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	LD BE COMPLET			
V 537	Continued From page	e 5	V 537				
	the broom; -staff #1 in the middle intervene; -client #1 comes runn side of the cottage an #3 lands face up in w top of client #3, they a each other; -at same time FS#3 re -staff #1 and FS#3 ge FS#3 grabs client #1 180 degree angle qui -wall right behind clien -client #1 hits wall and holds his nose; -at same time when c falls to floor; -staff #2 was also in t assisting in separating Interview on 9/25/18 v -was working during i -client #2 had broom,	ent #1 and FS#3; and falls to floor, gets up and client #1 hits wall, client #2 the middle of clients and clients. with staff #1 revealed:					

laying in the floor;
-client #1 hit the wall;

from client #2;

-FS#3 used the TCI "spin move;"

-FS#3 gets client #1 off client #3;

-grab clients by waist area, swing them around, place them away from the incident;

-from where he was standing, appeared FS#3 and client #1 tripped over the broom which was

-client #1 ran across cottage commons area and jumped client #3 who was trying to get broom

-saw client #1 falling to the ground;

-had no concerns with how FS#3 interacted with clients;

-had been working with FS#3 for about 3 weeks.

Division of Health Service Regulation

STATE FORM P9GC11 If continuation sheet 6 of 8

Division of Health Service Regulation							
	FOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED		
				<del></del>			
		NUL 0004007	B. WING		00/00/0040		
		MHL0601227			09/28/2018		
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	TE, ZIP CODE			
		6750 SA	INT PETERS LAN	JE SUITE 300			
MERANCA	AS COTTAGE		WS, NC 28105	12, 001.2 000			
	OLIMANA DV. OT			SECURE SIAN OF CORRECTION			
(X4) ID PREFIX		FATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	( - /		
TAG	,	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR			
				DEFICIENCY)			
\/ 527	Continue d Frame many		V 527				
V 537	Continued From page	e 6	V 537				
	Interview on 9/26/18	with staff #2 revealed:					
	-did not see what happened as had his back to						
	FS#3 and client #1;						
		#3 before, no concerns with					
	his interaction with cli						
		e, grab clients by waist area,					
	-	es while still holding onto					
		n the area and situation.					
	Interview on 9/25/18	with client #3 revealed:					
	-client #1 knocked hir	m into a chair;					
	-client #1 was trying t						
		t #1 to try to get him back;					
	-FS#3 spun client #1						
	-nurse came and saw						
	-FS#3 was "pretty go	od;"					
		when he spun client #1;					
	-did not "throw" client	: #1;					
	-saw them stumble;						
	-not sure if both stum	bled or only client #1.					
	Interview on 9/25/18	with client #2 revealed:					
	-client #1 and client #	<u> </u>					
		ere trying to split them up;					
	-client #1 tripped on F	FS#3's shoe and fell, hitting					
	wall;						
		lient #1, was not angry when					
		nt #1 away from client #3;					
		am any clients against the					
	wall;						
	-felt safe around FS#	3.					
		with client #1 revealed:					
	-was fighting client #3						
	-had tackled client #3						
		#3, he was punching him;					
		FS#3 were present trying to					
	break it up;	1. 1.66					
	-FS#3 grabbed him, s	spun him around in different					

Division of Health Service Regulation

STATE FORM 6899 P9GC11 If continuation sheet 7 of 8

Division of Health Service Regulation

				(X3) DATE SURVEY COMPLETED	
		A. BUILDING:			
	MHL0601227	B. WING		09/28/2018	
NAME OF PROVIDER OR SUPPLIER	STREET ADDR	RESS, CITY, STAT	TE, ZIP CODE		
MERANCAS COTTAGE		PETERS LAN	IE, SUITE 300		
		6, NC 28105			
PREFIX (EACH DEFICIENCY MUS	MENT OF DEFICIENCIES ST BE PRECEDED BY FULL DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE	
V 537 Continued From page 7		V 537			
direction, he flew/slamme -hit the wall and his nose -no problems before this v -FS#3 said he was sorry; -FS#3 was not mad at the Interview on 9/26/18 with -was trying to breakup a from and client #3; -client #1 was in the kitcher of kitchen and tackled client #1 was on top of clother in a chair; -did a TCI spin move to resituation; -TCI spin move involved gwaist area, spinning the order clients to separate; -did the TCI spin move, client #2, and hits the wall-did not slam client #1 into intentionally hurt a client; -was just trying to remove situation as taught in TCI	bled; with FS#3; e time it happened.  FS#3 revealed: fight between client #1  ten with staff #2, ran out ent #3; lient #3 punching each emove client #1 from the grabbing a client by the opposite way while staff between clients and ; client #1 trips, think over ll; o the wall, would never	V 537			

Division of Health Service Regulation

STATE FORM 6899 P9GC11 If continuation sheet 8 of 8