STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL024-104	A. BUILDING: _____ B. WING _____	10/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BURKHEAD GROUP HOME	411 WEST BURKHEAD STREET WHITEVILLE, NC 28472

(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 A complaint survey was completed on 10/1/18. The complaint was substantiated (intake #NC00142788). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities.	V 000		
V 108	27G .0202 (F-I) Personnel Requirements 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 following: (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	V 108		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL024-104	A. BUILDING: _____ B. WING _____	10/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BURKHEAD GROUP HOME	411 WEST BURKHEAD STREET WHITEVILLE, NC 28472

(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 108	Continued From page 1 and communicable diseases of personnel and clients. This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to ensure 3 of 3 direct care staff audited (#4, #7, and #10) received training to meet the needs of a newly admitted client (client #2) prior to providing care to the client. The findings are: Review on 9/27/18 and 9/28/18 of client #2's record revealed: -21 year old male admitted 9/7/18. -Diagnoses included Social (Pragmatic) Communication Disorder; Cyclothymic; Mild Intellectual Disability; Mild Neurocognitive Disorder, probably due to Parkinson's Disease with behavior disturbance. -Admission assessment dated 9/6/18 documented client #2 had a history of verbal and physical aggressive behaviors; destruction of property; disrespectful to others; inappropriate language; poor coping skills; "... can be angry when he doesn't get his way;" not following directions; smoked multiple times per day. -No copy of the admission assessment on client #2's record in the facility. (Copy of assessment provided at the Licensee/QP's office on 9/28/18) Review of 9/28/18 of facility incident report dated/timed 9/9/18 at 8:15 am revealed: -Client #2 asked Staff #10 for his cigarettes on 9/9/18 around 8 am. -Staff #10 read a note to client #2. According to	V 108		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL024-104	A. BUILDING: _____ B. WING _____	10/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BURKHEAD GROUP HOME	411 WEST BURKHEAD STREET WHITEVILLE, NC 28472

(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 108	Continued From page 2	V 108		

the note client #2's mother had stated she did not want the client to smoke.
-Client #2 became violent, knocked books off the desk, was "swinging" at the staff.
-Staff tried to redirect the client, put his arms up to protect himself from the client, then put the client in a therapeutic wrap.
-Client #2 dropped to the floor, causing the staff and client to fall.

Review on 9/25/18 of client #2's Emergency Room (ER) Record dated 9/9/18 revealed:
-Client #2 was triaged in the local ER on 9/9/18 at 8:58 pm.
-Client #2 was complaining of left shoulder pain and stated it "pops when he moves it."
-Client #2 was diagnosed with a distal left clavicle fracture.

Finding #1:
Review on 09/28/18 of Staff #4's personnel record revealed:
-Date of Hire on 02/22/18.
-No documentation of training to meet the needs of client #2.

Interview on 9/27/18 Staff #4 stated:
-On Sunday, 9/9/18, she relieved the night staff (Staff#10) and worked the day shift. Staff #10 reported to her they had a new admission, client #2. This was when she realized they had a new client. Staff #10 did not share any specific information about client #2.
-The Group Home Manager had told staff at some point prior to this shift on 9/9/18 they were getting a new client who had a guardian, but he said he could not give them more specific information until the client was admitted.
-Client #2 would go outside with other clients and they would give him a cigarette. A note was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL024-104	A. BUILDING: _____ B. WING _____	10/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BURKHEAD GROUP HOME	411 WEST BURKHEAD STREET WHITEVILLE, NC 28472

(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 108	Continued From page 3	V 108		

posted for staff that informed them that client #2's mother did not want him to smoke. This was what staff would tell the client. They did not try to stop him from smoking outside with other clients, because this was the clients' rights.

Finding #2:
Review on 09/28/18 of Staff #7's personnel record revealed:
-Date of Hire on 10/26/15.
-No documentation of training to meet the needs of client #2.

Interview on 9/27/18 Staff #7 stated:
-She typically worked 1 week end shift as a direct care staff. She worked full time for the Licensee in medical records at the office.
-On 9/9/18 she worked from about 10 am - 7 pm with Staff #4. She had only worked this 1 shift with client #2.
-When asked how she was informed about the needs of newly admitted clients she stated, "If I remember correctly the house manager gives us a general run down ... issues and approaches."
-When asked if she could recall any information given about client #2, her answer was, "No."
-It was her understanding when he came to the facility his mother brought cigarettes and said he could smoke, then called back and told staff she did not want him to smoke. Staff #7 told client #2 they would "figure this out...[client #2] thought he could smoke." She thought this was something she had been told; she had not seen this in writing.
-She did not know if the mother was the legal guardian.

Finding #3:
Review on 09/28/18 of Staff #10's personnel record revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL024-104	A. BUILDING: _____ B. WING _____	10/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BURKHEAD GROUP HOME	411 WEST BURKHEAD STREET WHITEVILLE, NC 28472

(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 108	Continued From page 4 -Date of Hire on 11-29-15 -No documentation of training to meet the needs of client #2. Interview on 9/28/18 Staff #10 stated: -He worked Saturday and Sunday night shifts, 8 pm - 8 am, as a Direct Care Staff. He reported to work on Saturday, 9/8/18 at 8 pm for his 12 hour shift. -He was told by the off going staff on 9/8/18 they had a new admission, client #2. He had been admitted from home where he lived with his mother. Client #2 was in bed asleep when Staff #10 arrived to work on 9/8/18 at 8 pm. -There was a note posted in the office that informed the staff client #2's mother did not want him to smoke, and that he could call his mother on Sunday between 6 pm - 8 pm. -Staff #10 had been provided no additional information, verbal or in writing, about client #2. -His first interaction with client #2 was around 8 am on 9/9/18 when client #2 requested his cigarettes. Staff #10 told him he did not have his cigarettes. He read the note to client #2 that instructed staff to not allow him to smoke according to his mother's request. -Client #2 told Staff #10 this was a lie and that he had been smoking and his mother had given him cigarettes. -Client #2 became increasingly irate, aggressive, and attacked Staff #10 in the office as he was preparing to administer the morning medications. Staff #10's efforts to get the client to calm failed and he put client #2 in a therapeutic hold. His goal was to remove the client away from the medication area, and into the living room. During the hold client #2 was able to push his feet against the wall causing Staff #10 to lose his balance, then he dropped his weight causing them to fall to the floor. After the fall the client	V 108		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL024-104	A. BUILDING: _____ B. WING _____	10/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BURKHEAD GROUP HOME	411 WEST BURKHEAD STREET WHITEVILLE, NC 28472

(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 108	Continued From page 5 denied he was injured. It was discovered that night when he took the client to the Emergency Room that he had sustained a fractured clavicle. -He did not know at the time client #2 had cigarettes in the top desk drawer because no one had informed him of such. Interview on 9/28/18 client #2 stated: -On the Saturday after he was admitted he was getting cigarettes. The staff would hand them to him. "... just giving me a little at a time." -The next morning the staff had told him he could not have a cigarette and had shown him a note. -On Sunday his peer in the room next to his gave him cigarettes and he smoked. Telephone interview on 9/28/18, client #2's mother stated: -She was his legal guardian. -She did not want client #2 to smoke, but had left him cigarettes with the staff. She had told the staff to give him the cigarettes "sparingly." Interview on 9/28/18 the Group Home Manager stated: -Client #2 was admitted on a Thursday night. -When a new client arrived to the facility they would get information about how the client reacted to things, how they were in general, and the different medications they took. The information was then recorded for staff to review. -For someone like Staff #10, a weekend staff, they would not be able to get the new information on the client for review. -The Group Home Manager was not certain who wrote the note regarding smoking and phone call restrictions. -At the present time client #2 did not have any smoking restrictions.	V 108		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL024-104	A. BUILDING: _____ B. WING _____	10/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BURKHEAD GROUP HOME	411 WEST BURKHEAD STREET WHITEVILLE, NC 28472

(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 108	Continued From page 6 Interview on 09/28/18 the Licensee/Qualified Professional (QP) stated: -The process for educating staff about new admissions included the QP reviewing things with the Group Home Manager and the Group Home Manager then reviewing the information with the staff. -The Group Home Manager usually followed protocol without incident, but she was not sure what happened with the manager's sharing information about client #2 with the staff. -The Group Home Manager was present with the Licensee/QP when she conducted the initial reviews of client #2 prior to admission, and again the night client #2's mother brought him to the facility for admission. They reviewed concerns and pertinent client history. -The Licensee/QP thought the Group Home Manager wrote the note regarding smoking and phone call restrictions. He got the information from the Licensee/QP following a phone call the day after client #2's admission when the mother stated she did not want him to smoke at all. This deficiency is cross referenced into 10A NCAC 27G .0203 COMPETENCIES OF QUALIFIED PROFESSIONALS AND ASSOCIATE PROFESSIONALS (V109) for a Type A1and must be corrected within 23 days.	V 108		
V 109	27G .0203 Privileging/Training Professionals 10A NCAC 27G .0203 COMPETENCIES OF QUALIFIED PROFESSIONALS AND ASSOCIATE PROFESSIONALS (a) There shall be no privileging requirements for qualified professionals or associate professionals. (b) Qualified professionals and associate professionals shall demonstrate knowledge, skills	V 109		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL024-104	A. BUILDING: _____ B. WING _____	10/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BURKHEAD GROUP HOME	411 WEST BURKHEAD STREET WHITEVILLE, NC 28472

(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 109	Continued From page 7 and abilities required by the population served. (c) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence. (d) Competence shall be demonstrated by exhibiting core skills including: (1) technical knowledge; (2) cultural awareness; (3) analytical skills; (4) decision-making; (5) interpersonal skills; (6) communication skills; and (7) clinical skills. (e) Qualified professionals as specified in 10A NCAC 27G .0104 (18)(a) are deemed to have met the requirements of the competency-based employment system in the State Plan for MH/DD/SAS. (f) The governing body for each facility shall develop and implement policies and procedures for the initiation of an individualized supervision plan upon hiring each associate professional. (g) The associate professional shall be supervised by a qualified professional with the population served for the period of time as specified in Rule .0104 of this Subchapter. This Rule is not met as evidenced by: Based on record reviews and interviews, 1 of 1 qualified professional staff audited(Licensee/Qualified Professional (QP)), failed to demonstrate the decision-making, communication, knowledge, skills and abilities required by the population served. The findings are:	V 109		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL024-104	A. BUILDING: _____ B. WING _____	10/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BURKHEAD GROUP HOME	411 WEST BURKHEAD STREET WHITEVILLE, NC 28472

(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 109	Continued From page 8 Cross Reference: 10A NCAC 27G .0202 PERSONNEL REQUIREMENTS (V108). Based on record reviews and interviews the facility failed to ensure 3 of 3 direct care staff audited (#4, #7, and #10) received training to meet the needs of a newly admitted client (client #2) prior to providing care to the client. Interview on 09/28/18 the Licensee/Qualified Professional (QP) stated: -She (Licensee/QP) was filling in for the regular QP who was on medical leave. -The Licensee/QP completed an admission assessment for client #2 before he was admitted and then additions were added the Thursday night he arrived. -Smoking had been discussed during client #2's admission the night of 9/6/18. The client's mother did not want him to smoke, but agreed to leave him a pack of cigarettes. -When asked who made client #2 aware of the change from being allowed to smoke and not allowed to smoke, the Licensee/QP stated the Group Home Manager would have discussed the no smoking rule with Client #2. -The Licensee/QP did not discuss this with the client. -Client #2's Case Manager notified the facility that if someone else gave client #2 a cigarette the staff could not take it from him, so client #2 started getting cigarettes from other housemates. Review on 9/28/18 of the Plan of Protection, completed and signed by the QP Supervisor on 9/28/18 revealed: -"What will you immediately do to correct the above rule violation in order to protect clients from further risk or additional harm? QP will review group home schedule to see who is	V 109		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL024-104	A. BUILDING: _____ B. WING _____	10/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BURKHEAD GROUP HOME	411 WEST BURKHEAD STREET WHITEVILLE, NC 28472

(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 109	Continued From page 9 working this week end and if all staff is familiar with [client #2]. QP will post a note at the group for all staff scheduled to work the week end review all of [client #2's] file and information. QP will review staff's files to see who needs NCI (North Carolina Interventions) Part A and B." -"Describe your plan to make sure the above happens. QP will go to group home today to review with staff client's file and inform staff to let the staff know on the next shift to review clients file. QP will arrange training for staff who needs's NCI Part A&B." Client #2 was admitted on the evening of 9/6/18 with diagnoses of Social (Pragmatic) Communication Disorder; Cyclothymic; Mild Intellectual Disability and Mild Neurocognitive Disorder. Based on admission assessment completed by the Licensee/QP but not shared with staff, his presenting problems included getting upset when confronted; aggressive behaviors, both verbal and physical; property destruction; disrespectful to others; inappropriate language; and poor coping skills. He was known to become angry when he did not "get his way." Upon admission, client #2's mother/guardian requested that he be given cigarettes "sparingly." Licensee/QP stated the mother then called back and stated she didn't want the client to have any cigarettes "at all." The failure of the Licensee/QP to ensure staff were trained on the needs of client #2, and changes in his plan with respect to smoking, and the failure to ensure client #2 understood the change to not allow him to smoke, led to inconsistencies in staff's response to the client's request for cigarettes. When Staff #10 met client #2 on the morning of 9/9/18 for the first time, he followed the instructions on the posted note which stated client #2 was not to have cigarettes and could only call his mom on	V 109		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL024-104	A. BUILDING: _____ B. WING _____	10/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BURKHEAD GROUP HOME	411 WEST BURKHEAD STREET WHITEVILLE, NC 28472

(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 109	Continued From page 10 Sunday nights between 6PM and 8PM. Client#2 became angry, his behaviors escalated, and he physically attacked Staff #10 and was placed in a therapeutic hold. During the hold they fell to the floor and client #2 sustained a fractured clavicle. As a result of staff not being trained by the Licensee/QP, staff were untrained to address the needs of client #2 which resulted in a serious injury. This deficiency constitutes a Type A1 rule violation for serious harm and must be corrected within 23 days. An Administrative Penalty of $2000.00 is imposed. If the violation is not corrected within 23 days, an additional administrative penalty of $500 dollars per day will be imposed for each day the facility is out of compliance beyond the 23rd day.	V 109		
V 111	27G .0205 (A-B) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (a) An assessment shall be completed for a client, according to governing body policy, prior to the delivery of services, and shall include, but not be limited to: (1) the client's presenting problem; (2) the client's needs and strengths; (3) a provisional or admitting diagnosis with an established diagnosis determined within 30 days of admission, except that a client admitted to a detoxification or other 24-hour medical program shall have an established diagnosis upon admission; (4) a pertinent social, family, and medical history; and (5) evaluations or assessments, such as psychiatric, substance abuse, medical, and	V 111		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL024-104	A. BUILDING: _____ B. WING _____	10/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BURKHEAD GROUP HOME	411 WEST BURKHEAD STREET WHITEVILLE, NC 28472

(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 111	Continued From page 11 vocational, as appropriate to the client's needs. (b) When services are provided prior to the establishment and implementation of the treatment/habilitation or service plan, hereafter referred to as the "plan," strategies to address the client's presenting problem shall be documented. This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to develop and implement strategies to address the client's presenting problems prior to the establishment and implementation of the treatment plan affecting 1 of 3 clients audited (client #2). The findings are: Review on 9/27/18 of client #2's record revealed: -21 year old male admitted 9/7/18. -Diagnoses included Social (Pragmatic) Communication Disorder; Cyclothymic; Mild Intellectual Disability; Mild Neurocognitive Disorder, probably due to Parkinson's Disease with behavior disturbance. -No strategies documented to limit smoking. -No strategies documented to address smoking cessation and/or nicotine withdrawal. -The admission assessment was not in client #2's record located in the group home, and therefore, not available for staff review. Review on 9/28/18 of client #2's admission assessment dated 9/6/18 revealed: -"Presenting Problems: [Client #2] gets upset	V 111		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL024-104	A. BUILDING: _____ B. WING _____	10/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BURKHEAD GROUP HOME	411 WEST BURKHEAD STREET WHITEVILLE, NC 28472

(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 111	Continued From page 12	V 111		

when he is confronted about things, ... aggressive, verbally & physically; stealing; destruction of property; disrespectful to others; inappropriate language; poor coping skills; fuses and screams when upset; he lies."
-"... can be angry when he doesn't get his way"
-"... hospitalized on 7/30/18; threats...has been arrested 4 times this year"
-"Individualized Needs/Weaknesses: aggression not following directions
-Legal charges (4 misdemeanors) pending. Offenses included stealing, property destruction and driving without a license.
-Currently smoked daily, multiple times per day.
-When he must do something he did not want to do he would get angry, agitated, and curse. He could be calmed by going outside, talked to, allowed to have some alone time, but not long because he tended to put himself in harms way.

Review on 9/27/18 of hand written sign dated 9/7/18 revealed:
-Sign read, "Attention: [client #2] can talk with his mom on Sunday 6 pm - 8 pm His mom does not want him smoking. please comply with these instructions. per Management"
-No signature on sign.

Review of 9/28/18 of facility incident report dated/timed 9/9/18 at 8:15 am revealed:
-Client #2 became verbally and physically aggressive when Staff #10 told him he could not give him a cigarette.
-Staff #10 tried to redirect the client, Staff #10 put his arms up to protect himself, then put client #2 in a therapeutic wrap.
-The client dropped his weight causing the staff and client to fall. After falling the client continued to be aggressive by kicking and attempting to bite the staff.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL024-104	A. BUILDING: _____ B. WING _____	10/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BURKHEAD GROUP HOME	411 WEST BURKHEAD STREET WHITEVILLE, NC 28472

(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 111	Continued From page 13 Interview on 9/28/18 client #2 stated: -On the Saturday after he was admitted he was getting cigarettes. The staff would hand them to him. "... just giving me a little at a time." -The next morning the staff had told him he could not have a cigarette and had shown him a note. -On Sunday his peer in the room next to his gave him cigarettes and he smoked. Telephone interview on 9/28/18, client #2's mother stated: -She was his legal guardian. -She did not want client #2 to smoke and told the staff to give him cigarettes "sparingly." Interview on 9/28/18 Staff #10 stated: -Client #2 was in bed asleep when he arrived to work on 9/8/18 at 8 pm. His shift was 8 pm - 8 am. -This was the first time he had worked with this client. He had not had the opportunity to interact with client #2 until the morning of 9/9/18. -Client #2 requested his cigarettes around 8 am. Staff #10 told him he did not have his cigarettes. He read the note to client #2 that instructed staff to not allow the client to smoke according to his mother. -Staff #10 told the client he could discuss this with his mother when he had his phone call between 6 pm and 8 pm. -Client #2 told Staff #10 this was a lie and that he had been smoking. -Client #2 became verbally and physically aggressive. He had to put client #2 in a therapeutic hold. -He did not know at the time the client had cigarettes in the top desk drawer. -When he took report on 9/8/18 he had been told they had a new admission who was admitted	V 111		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL024-104	A. BUILDING: _____ B. WING _____	10/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BURKHEAD GROUP HOME	411 WEST BURKHEAD STREET WHITEVILLE, NC 28472

(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 111	Continued From page 14	V 111		

from home where he lived with his mother.
-At the time of the incident he had no additional information about client#2.
-There was nothing in writing about client #2.

Interview on 9/28/18 the Group Home Manager stated:
-Client #2 was admitted on a Thursday night.
-When a new client arrived to the facility they would get information about how the client reacted to things, how they were in general, and the different medications they took. The information was then recorded for staff to review.
-For someone like Staff #10, a weekend staff, they would not be able to get the new information on the client for review.
-The Group Home Manager was not certain who wrote the note regarding smoking and phone call restrictions.
-At the present time client #2 did not have restrictions of cigarette smoking.

Interview on 9/28/18 the Licensee/Qualified Professional (QP) stated:
-Smoking had been discussed during client #2's admission the night of 9/7/18. The client's mother did not want him to smoke, but agreed to leave him a pack of cigarettes.
-The next day she spoke with the client's mother on the phone, and the mother stated she did not want client #2 to smoke at all. The Licensee/QP then spoke with the Group Home Manager and he wrote the note.
-The Case Manager notified them that if someone else gave client #2 a cigarette it could not be taken from him, so he started getting cigarettes from other housemates.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL024-104	A. BUILDING: _____ B. WING _____	10/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BURKHEAD GROUP HOME	411 WEST BURKHEAD STREET WHITEVILLE, NC 28472

(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 291	Continued From page 15	V 291		
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, 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, observations, and interviews, the facility failed to maintain coordination among the medical providers responsible for client treatment, affecting 1 of 3	V 291		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL024-104	A. BUILDING: _____ B. WING _____	10/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BURKHEAD GROUP HOME	411 WEST BURKHEAD STREET WHITEVILLE, NC 28472

(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 291	Continued From page 16 audited clients (client #2). The findings are: Review on 9/27/18 and 9/28/18 of client #2's record revealed: -21 year old male admitted 9/7/18. -Diagnoses included Social (Pragmatic) Communication Disorder; Cyclothymic; Mild Intellectual Disability; Mild Neurocognitive Disorder, probably due to Parkinson's Disease with behavior disturbance. Review of 9/28/18 of facility incident report dated/timed 9/9/18 at 8:15 am revealed: -On 9/9/18 around 8 am client #2 became violent, knocked books off the desk, was "swinging" at the staff. -Staff #10 tried to redirect the client; Staff #10 put his arms up to protect himself from the client; then, Staff #10 put the client in a therapeutic wrap. -Client #2 dropped to the floor, causing the staff and client to fall. Review on 9/25/18 of client #2's Emergency Room (ER) Record dated 9/9/18 revealed: -Client #2 was triaged in the local ER on 9/9/18 at 8:58 pm. -Client #2 was from a group home and reported "wrestling" with staff on 9/9/18. -Client #2 was complaining of left shoulder pain and stated it "pops when he moves it." -The facility staff did not bring client #2's history or medication list to the ER. -Client #2 stated his pain level was a 10 out of 10 on the hospital pain scale. He was given Acetaminophen 1,000 mg (milligrams) and Ibuprofen 800 mg for pain. -X-rays were done and client #2 was diagnosed with a distal left clavicle fracture. -Client #2 was discharged back to the group	V 291		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL024-104	A. BUILDING: _____ B. WING _____	10/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BURKHEAD GROUP HOME	411 WEST BURKHEAD STREET WHITEVILLE, NC 28472

(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 291	Continued From page 17 home at 11:40 pm. Interview on 9/28/18 client #2 stated: -He asked a staff for his cigarettes on a morning. The staff was in the office and told him he could not have a cigarette and showed him a note. -"He grabbed me with my hands in front of me and then I dropped to the ground to get out and he fell on me. -"I kept telling staff that were coming in that I needed to go to the hospital and nobody did anything." Telephone interview on 9/28/18 client #2's mother/guardian stated: -Her son was suppose to call her on Sunday at 6 pm. She had not received a call by 7 pm so she called the group home. -Her son told her that he and a staff had gotten into an argument about his cigarettes and the staff had jumped on him. Her son was crying and it was not typical for him to cry. -Her son told her he had been begging the staff to take him to the ER because his arm hurt but they would not take him. It had been 12 hours since he was hurt. -She called the Licensee/Qualified Professional (QP). -If she had not called the Licensee/QP he would never have been taken to the ER. Interview on 9/28/18 Staff #10 stated: -Following the therapeutic hold the client said he was "ok." -He called and reported the situation to the Licensee/QP later in the morning. -He spoke with the Group Home Manager later that day around 5 pm - 6 pm. He was told client #2 had been complaining of pain. -Staff #4 had been instructed by the Licensee/QP	V 291		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL024-104	A. BUILDING: _____ B. WING _____	10/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BURKHEAD GROUP HOME	411 WEST BURKHEAD STREET WHITEVILLE, NC 28472

(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 291	Continued From page 18 to take client #2 to the ER. -Staff #10 took client #2 to the ER after he reported for his shift on 9/9/18 at 8 pm. Interview on 9/27/18 Staff #7 stated: -She worked Sunday, 9/9/18, from 10 am - 7 pm with staff #4. -Client #2 had complained of shoulder hurting as soon as she got to work on 9/9/18. -She did not realize he had been put in a "hold." He would complain of pain, then move his arms around, so she did not realize he was hurt. -She thought she made a call about client #2's complaints of pain, but could not remember specifically what she did. She got off work at 7 pm and he went to the ER after she left. Interview on 9/27/18 Staff #4 stated: -On 9/9/18 she relieved Staff #10. -Staff #10 reported to her that he had to put client #2 into a restraint; he did not go into details. Staff #10 said he was getting ready to call the Licensee/QP. -Staff #10 did not report an injury. -Client #2 first complained of pain when Staff #7 got to work. -Client #2 never talked to her about what had happened before she came to work on 9/9/18. He told Staff #7 his shoulder hurt, then he would watch TV, "jump around," and go smoke. He would go outside with the other clients and they would give him a cigarette. Interview on 9/28/18 the Licensee/QP stated: -Staff #10 drove client #2 to the ER. -She and the Group Home Manager and 2 other staff met them at the hospital.	V 291		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL024-104	A. BUILDING: _____ B. WING _____	10/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BURKHEAD GROUP HOME	411 WEST BURKHEAD STREET WHITEVILLE, NC 28472

(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 364	Continued From page 19	V 364		
V 364	G.S. 122C- 62 Additional Rights in 24 Hour Facilities § 122C-62. Additional Rights in 24-Hour Facilities. (a) In addition to the rights enumerated in G.S. 122C-51 through G.S. 122C-61, each adult client who is receiving treatment or habilitation in a 24-hour facility keeps the right to: (1) Send and receive sealed mail and have access to writing material, postage, and staff assistance when necessary; (2) Contact and consult with, at his own expense and at no cost to the facility, legal counsel, private physicians, and private mental health, developmental disabilities, or substance abuse professionals of his choice; and (3) Contact and consult with a client advocate if there is a client advocate. The rights specified in this subsection may not be restricted by the facility and each adult client may exercise these rights at all reasonable times. (b) Except as provided in subsections (e) and (h) of this section, each adult client who is receiving treatment or habilitation in a 24-hour facility at all times keeps the right to: (1) Make and receive confidential telephone calls. All long distance calls shall be paid for by the client at the time of making the call or made collect to the receiving party; (2) Receive visitors between the hours of 8:00 a.m. and 9:00 p.m. for a period of at least six hours daily, two hours of which shall be after 6:00 p.m.; however visiting shall not take precedence over therapies; (3) Communicate and meet under appropriate supervision with individuals of his own choice upon the consent of the individuals; (4) Make visits outside the custody of the facility	V 364		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL024-104	A. BUILDING: _____ B. WING _____	10/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BURKHEAD GROUP HOME	411 WEST BURKHEAD STREET WHITEVILLE, NC 28472

(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 364	Continued From page 20 unless: a. Commitment proceedings were initiated as the result of the client's being charged with a violent crime, including a crime involving an assault with a deadly weapon, and the respondent was found not guilty by reason of insanity or incapable of proceeding; b. The client was voluntarily admitted or committed to the facility while under order of commitment to a correctional facility of the Division of Adult Correction of the Department of Public Safety; or c. The client is being held to determine capacity to proceed pursuant to G.S. 15A-1002; A court order may expressly authorize visits otherwise prohibited by the existence of the conditions prescribed by this subdivision; (5) Be out of doors daily and have access to facilities and equipment for physical exercise several times a week; (6) Except as prohibited by law, keep and use personal clothing and possessions, unless the client is being held to determine capacity to proceed pursuant to G.S. 15A-1002; (7) Participate in religious worship; (8) Keep and spend a reasonable sum of his own money; (9) Retain a driver's license, unless otherwise prohibited by Chapter 20 of the General Statutes; and (10)Have access to individual storage space for his private use. (c) In addition to the rights enumerated in G.S. 122C-51 through G.S. 122C-57 and G.S. 122C-59 through G.S. 122C-61, each minor client who is receiving treatment or habilitation in a 24-hour facility has the right to have access to proper adult supervision and guidance. In recognition of the minor's status as a developing	V 364		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL024-104	A. BUILDING: _____ B. WING _____	10/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BURKHEAD GROUP HOME	411 WEST BURKHEAD STREET WHITEVILLE, NC 28472

(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 364	Continued From page 21 individual, the minor shall be provided opportunities to enable him to mature physically, emotionally, intellectually, socially, and vocationally. In view of the physical, emotional, and intellectual immaturity of the minor, the 24-hour facility shall provide appropriate structure, supervision and control consistent with the rights given to the minor pursuant to this Part. The facility shall also, where practical, make reasonable efforts to ensure that each minor client receives treatment apart and separate from adult clients unless the treatment needs of the minor client dictate otherwise. Each minor client who is receiving treatment or habilitation from a 24-hour facility has the right to: (1) Communicate and consult with his parents or guardian or the agency or individual having legal custody of him; (2) Contact and consult with, at his own expense or that of his legally responsible person and at no cost to the facility, legal counsel, private physicians, private mental health, developmental disabilities, or substance abuse professionals, of his or his legally responsible person's choice; and (3) Contact and consult with a client advocate, if there is a client advocate. The rights specified in this subsection may not be restricted by the facility and each minor client may exercise these rights at all reasonable times. (d) Except as provided in subsections (e) and (h) of this section, each minor client who is receiving treatment or habilitation in a 24-hour facility has the right to: (1) Make and receive telephone calls. All long distance calls shall be paid for by the client at the time of making the call or made collect to the receiving party; (2) Send and receive mail and have access to writing materials, postage, and staff assistance	V 364		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL024-104	A. BUILDING: _____ B. WING _____	10/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BURKHEAD GROUP HOME	411 WEST BURKHEAD STREET WHITEVILLE, NC 28472

(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 364	Continued From page 22 when necessary; (3) Under appropriate supervision, receive visitors between the hours of 8:00 a.m. and 9:00 p.m. for a period of at least six hours daily, two hours of which shall be after 6:00 p.m.; however visiting shall not take precedence over school or therapies; (4) Receive special education and vocational training in accordance with federal and State law; (5) Be out of doors daily and participate in play, recreation, and physical exercise on a regular basis in accordance with his needs; (6) Except as prohibited by law, keep and use personal clothing and possessions under appropriate supervision, unless the client is being held to determine capacity to proceed pursuant to G.S. 15A-1002; (7) Participate in religious worship; (8) Have access to individual storage space for the safekeeping of personal belongings; (9) Have access to and spend a reasonable sum of his own money; and (10)Retain a driver's license, unless otherwise prohibited by Chapter 20 of the General Statutes. (e) No right enumerated in subsections (b) or (d) of this section may be limited or restricted except by the qualified professional responsible for the formulation of the client's treatment or habilitation plan. A written statement shall be placed in the client's record that indicates the detailed reason for the restriction. The restriction shall be reasonable and related to the client's treatment or habilitation needs. A restriction is effective for a period not to exceed 30 days. An evaluation of each restriction shall be conducted by the qualified professional at least every seven days, at which time the restriction may be removed. Each evaluation of a restriction shall be documented in the client's record. Restrictions on	V 364		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL024-104	A. BUILDING: _____ B. WING _____	10/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BURKHEAD GROUP HOME	411 WEST BURKHEAD STREET WHITEVILLE, NC 28472

(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 364	Continued From page 23 rights may be renewed only by a written statement entered by the qualified professional in the client's record that states the reason for the renewal of the restriction. In the case of an adult client who has not been adjudicated incompetent, in each instance of an initial restriction or renewal of a restriction of rights, an individual designated by the client shall, upon the consent of the client, be notified of the restriction and of the reason for it. In the case of a minor client or an incompetent adult client, the legally responsible person shall be notified of each instance of an initial restriction or renewal of a restriction of rights and of the reason for it. Notification of the designated individual or legally responsible person shall be documented in writing in the client's record. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility used procedures that restricted clients' rights to make/receive telephone calls, receive visitors, and meet with individuals of their choosing, and failed to document reasons for restrictions related to the client's treatment or habilitation needs, affecting 1 of 3 clients audited (client #2). The findings are: Review on 9/27/18 of client #2's record revealed: -21 year old male admitted 9/7/18. -Diagnoses included Social (Pragmatic) Communication Disorder; Cyclothymic; Mild Intellectual Disability; Mild Neurocognitive Disorder, probably due to Parkinson's Disease with behavior disturbance. -No documentation the visitation or phone call restrictions related to the client's treatment or habilitation needs.	V 364		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL024-104	A. BUILDING: _____ B. WING _____	10/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BURKHEAD GROUP HOME	411 WEST BURKHEAD STREET WHITEVILLE, NC 28472

(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 364	Continued From page 24 Review on 9/27/18 of hand written sign dated 9/7/18 revealed: -Sign read, "Attention: [client #2] can talk with his mom on Sunday 6 pm - 8 pm His mom does not want him smoking. please comply with these instructions. per Management" -No signature on sign. Review on 9/28/18 of the facility policy, "Admissions: Visits and Calls" revealed: -"When a client is initially admitted to the facility; Family Members and friends cannot visit client for 30 days unless it is preappoved by Administration/Qualified Professional (QP). If Client has good behaviors, stay on tasks and follow group home policy and procedures visits can be permitted within 7 days." -"Clients and/or family members can have contact via phones/visits/emails 1-2 times a week." -"Clients are not to be on the phone no more than 30 minutes at a time per call to respect other residents and allow other residents to use the phone." Interview on 9/28/18 client #2's mother/guardian stated: -She had been told by the Licensee/Qualified Professional (QP) she could not call or visit her son for 30 days following his admission. -The Licensee/QP assured her nothing would happen. -Client #2's Case Worker had it arranged for her son to call her at 6 pm on Sunday. Interview on 9/28/18 the Licensee/QP stated: -It was the facility policy to restrict phone calls and visits during the first 30 days of a client's admission. -The policy was in writing.	V 364		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL024-104	A. BUILDING: _____ B. WING _____	10/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BURKHEAD GROUP HOME	411 WEST BURKHEAD STREET WHITEVILLE, NC 28472

(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 519	27E .0104(e3-7) 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: (3) the process for identifying, training, assessing competence of facility employees who may authorize and implement restrictive interventions; (4) the duties and responsibilities of responsible professionals regarding the use of restrictive interventions; (5) the person responsible for documentation when restrictive interventions are used; (6) the person responsible for the notification of others when restrictive interventions are used; and (7) the person responsible for checking the client's physical and psychological well-being and assessing the possible consequences of the use of a restrictive intervention and, in such cases there shall be procedures regarding: (A) documentation if a client has a physical disability or has had surgery that would make affected nerves and bones sensitive to injury; and (B) the identification and documentation of alternative emergency procedures, if needed; This Rule is not met as evidenced by: Based on interview and record review, the facility failed to develop and implement a policy and procedure for restrictive interventions. The findings are: Interview on 9/28/18 the Licensee/Qualified	V 519		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL024-104	A. BUILDING: _____ B. WING _____	10/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BURKHEAD GROUP HOME	411 WEST BURKHEAD STREET WHITEVILLE, NC 28472

(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 519	Continued From page 26 Professional (QP) stated: -The policy and procedure for restrictive interventions could not be located. -The policy may have been with the QP who was on medical leave of absence. -A copy of the policy and procedure would be faxed by 5 pm on 10/1/18. On 10/1/18 no Restrictive Intervention Policy and Procedure had been received.	V 519		
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 methods of intervention; (F) a description of the debriefing and planning with the client and the legally responsible person,	V 521		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL024-104	A. BUILDING: _____ B. WING _____	10/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BURKHEAD GROUP HOME	411 WEST BURKHEAD STREET WHITEVILLE, NC 28472

(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 521	Continued From page 27 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 reviews and interviews, the facility failed to document restrictive interventions in the client's record as required affecting 1 of 3 audited clients (#2). The findings are: Review on 9/27/18 and 9/28/18 of client #2's record revealed: -21 year old male admitted 9/7/18. -Diagnoses included Social (Pragmatic) Communication Disorder; Cyclothymic; Mild Intellectual Disability; Mild Neurocognitive Disorder, probably due to Parkinson's Disease with behavior disturbance. Review on 9/28/18 of facility incident report dated/timed 9/9/18 at 8:15 am revealed: -On 9/9/18 around 8 am client #2 became violent, knocked books off the desk, was "swinging" at the staff. -Staff #10 tried to redirect the client; Staff #10 put his arms up to protect himself from the client; then, Staff #10 put the client in a therapeutic wrap. -Client #2 dropped to the floor, causing the staff and client to fall.	V 521		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL024-104	A. BUILDING: _____ B. WING _____	10/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BURKHEAD GROUP HOME	411 WEST BURKHEAD STREET WHITEVILLE, NC 28472

(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 521	Continued From page 28 Review on 9/25/18 of client #2's Emergency Room (ER) Record dated 9/9/18 revealed: -Client #2 was triaged in the local ER on 9/9/18 at 8:58 pm. -Client #2 was from a group home and reported "wrestling" with staff on 9/9/18. -Client #2 was complaining of left shoulder pain and stated it "pops when he moves it." -X-rays were done and client #2 was diagnosed with a distal left clavicle fracture. Review of client #2's staff notes dated 9/9/18 revealed: -Staff note signed/dated by Staff #10 documented, "Client woke up and came into the office for a cigarette. Staff instructed that his mother wanted to stop smoking. Client got upset and attack Staff. Client was put in a therapeutic wrap. After calm client ate breakfast and took medications. Staff assisted him in areas of need." -There was no other documentation in client #2's record about the restrictive intervention. Interview on 9/28/18 the Licensee/Qualified Professional (QP)stated: -Restrictive interventions are documented on the incident report. -There was no documentation in the client record. -The debriefing was done by the QP Supervisor, the Associate Professional, and Director.	V 521		
V 537	27E .0108 Client Rights - Training in Sec Rest & ITO 10A NCAC 27E .0108 TRAINING IN SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT	V 537		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL024-104	A. BUILDING: _____ B. WING _____	10/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BURKHEAD GROUP HOME	411 WEST BURKHEAD STREET WHITEVILLE, NC 28472

(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 537	Continued From page 29 (a) Seclusion, physical restraint and isolation time-out may be employed only by staff who have been trained and have demonstrated competence in the proper use of and alternatives to these procedures. Facilities shall ensure that staff authorized to employ and terminate these procedures are retrained and have demonstrated competence at least annually. (b) Prior to providing direct care to people with disabilities whose treatment/habilitation plan includes restrictive interventions, staff including service providers, employees, students or volunteers shall complete training in the use of seclusion, physical restraint and isolation time-out and shall not use these interventions until the training is completed and competence is demonstrated. (c) A pre-requisite for taking this training is demonstrating competence by completion of training in preventing, reducing and eliminating the need for restrictive interventions. (d) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (e) Formal refresher training must be completed by each service provider periodically (minimum annually). (f) Content of the training that the service provider plans to employ must be approved by the Division of MH/DD/SAS pursuant to Paragraph (g) of this Rule. (g) Acceptable training programs shall include, but are not limited to, presentation of: (1) refresher information on alternatives to the use of restrictive interventions; (2) guidelines on when to intervene	V 537		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL024-104	A. BUILDING: _____ B. WING _____	10/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BURKHEAD GROUP HOME	411 WEST BURKHEAD STREET WHITEVILLE, NC 28472

(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 537	Continued From page 30 (understanding imminent danger to self and others); (3) emphasis on safety and respect for the rights and dignity of all persons involved (using concepts of least restrictive interventions and incremental steps in an intervention); (4) strategies for the safe implementation of restrictive interventions; (5) the use of emergency safety interventions which include continuous assessment and monitoring of the physical and psychological well-being of the client and the safe use of restraint throughout the duration of the restrictive intervention; (6) prohibited procedures; (7) debriefing strategies, including their importance and purpose; and (8) documentation methods/procedures. (h) Service providers shall maintain documentation of initial and refresher training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcomes (pass/fail); (B) when and where they attended; and (C) instructor's name. (2) The Division of MH/DD/SAS may review/request this documentation at any time. (i) Instructor Qualification and Training Requirements: (1) Trainers shall demonstrate competence by scoring 100% on testing in a training program aimed at preventing, reducing and eliminating the need for restrictive interventions. (2) Trainers shall demonstrate competence by scoring 100% on testing in a training program teaching the use of seclusion, physical restraint and isolation time-out. (3) Trainers shall demonstrate competence	V 537		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL024-104	A. BUILDING: _____ B. WING _____	10/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BURKHEAD GROUP HOME	411 WEST BURKHEAD STREET WHITEVILLE, NC 28472

(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 537	Continued From page 31 by scoring a passing grade on testing in an instructor training program. (4) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (5) 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. (6) Acceptable instructor training programs shall include, but not be limited to, presentation of: (A) understanding the adult learner; (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.	V 537		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL024-104	A. BUILDING: _____ B. WING _____	10/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BURKHEAD GROUP HOME	411 WEST BURKHEAD STREET WHITEVILLE, NC 28472

(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 537	Continued From page 32 (1) Documentation shall include: (A) who participated in the training and the outcome (pass/fail); (B) when and where they attended; and (C) instructor's name. (2) The Division of MH/DD/SAS may review/request this documentation at any time. (l) Qualifications of Coaches: (1) Coaches shall meet all preparation requirements as a trainer. (2) Coaches shall teach at least three times, the course which is being coached. (3) 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 two of three audited staff (#4, #7) received annual training updates in seclusion, physical restraint and isolation time-out. The findings are: Review on 09/28/18 of staff #4's personnel record revealed: -Date of Hire: 02/22/18. -No current training in seclusion, physical restraint and isolation time-out. Review on 09/28/18 of staff #7's personnel record revealed: -Date of hire: 10/26/15. -North Carolina Interventions (NCI) training in seclusion, physical restraint and isolation time-out expired 03/27/17.	V 537		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL024-104	A. BUILDING: _____ B. WING _____	10/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BURKHEAD GROUP HOME	411 WEST BURKHEAD STREET WHITEVILLE, NC 28472

(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 537	Continued From page 33 -No current training in seclusion, physical restraint and isolation time-out. Interview on 09/28/18 the Licensee/Qualified Professional stated: -Staff had not required previous training in seclusion, physical restraint and isolation time-out due to minimal behaviors of previous clients served. -She acknowledged client #2, admitted 9/7/18, had a history of physical aggression and had been physically restrained around 8 am on the morning of 9/9/18 by Staff #10. After Staff #10 completed his night shift on 9/9/18, Staff #4 and Staff #7 were the only staff on duty until his return at 8 pm that evening.	V 537		