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V 000	INITIAL COMMENTS An annual Survey was completed on January 9, 2019. Deficiencies were cited. This facility is licensed for the following services category: 10A NCAC 27G .5600A Supervised Living for Adults with Mental Illness.	V 000		
V 105	27G .0201 (A) (1-7) Governing Body Policies 10A NCAC 27G .0201 GOVERNING BODY POLICIES (a) The governing body responsible for each facility or service shall develop and implement written policies for the following: (1) delegation of management authority for the operation of the facility and services; (2) criteria for admission; (3) criteria for discharge; (4) admission assessments, including: (A) who will perform the assessment; and (B) time frames for completing assessment. (5) client record management, including: (A) persons authorized to document; (B) transporting records; (C) safeguard of records against loss, tampering, defacement or use by unauthorized persons; (D) assurance of record accessibility to authorized users at all times; and (E) assurance of confidentiality of records. (6) screenings, which shall include: (A) an assessment of the individual's presenting problem or need; (B) an assessment of whether or not the facility can provide services to address the individual's needs; and (C) the disposition, including referrals and recommendations; (7) quality assurance and quality improvement activities, including:	V 105		

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V 105	Continued From page 1 (A) composition and activities of a quality assurance and quality improvement committee; (B) written quality assurance and quality improvement plan; (C) methods for monitoring and evaluating the quality and appropriateness of client care, including delineation of client outcomes and utilization of services; (D) professional or clinical supervision, including a requirement that staff who are not qualified professionals and provide direct client services shall be supervised by a qualified professional in that area of service; (E) strategies for improving client care; (F) review of staff qualifications and a determination made to grant treatment/habilitation privileges: (G) review of all fatalities of active clients who were being served in area-operated or contracted residential programs at the time of death; (H) adoption of standards that assure operational and programmatic performance meeting applicable standards of practice. For this purpose, "applicable standards of practice" means a level of competence established with reference to the prevailing and accepted methods, and the degree of knowledge, skill and care exercised by other practitioners in the field; This Rule is not met as evidenced by: Based on record review and interview, the facility failed to develop and implement adoption of standards that ensured operational and	V 105		

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V 105	Continued From page 2	V 105		

programmatic performance meeting applicable standards of practice for the use of a Glucometer instrument including the CLIA (Clinical Laboratory Improvement Amendments) waiver. The findings are:

Review on 1/9/19 of the facility's records revealed:
-There was no evidence of a CLIA waiver.

Review on 1/9/19 of Client #1's record revealed:
-Admission date of 11/26/16.
-Diagnoses of Chronic Paranoid Schizophrenia, Personality Disorder, Asthma, Sleep Apnea, Type 2 Diabetes, Hypertension, Hypothyroidism.
-Physician's orders dated 12/3/18:
Truetrack Blood Glucose Monitoring System-Finger Stick Blood Sugar, Check once a day and keep record.

Interview on 1/9/19 with Staff #1 revealed:
-Staff checked Client #1's blood sugars.
-Staff were required to check Client #1's blood sugar every day.
-She had never heard of the CLIA waiver.
-She was not aware the group home needed a CLIA waiver in order to check Clients #1's blood sugars.

Interview on 1/9/19 with the Owner/Director revealed:
-He had never heard of a CLIA waiver.
-He was not aware the facility needed a CLIA waiver in order to check a client's blood sugar levels.
-He confirmed the facility failed to have a CLIA waiver in order to complete blood sugar checks.
-He informed that he would apply for a CLIA waiver.

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V 112	Continued From page 3	V 112		
V 112	27G .0205 (C-D) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (c) The plan shall be developed based on the assessment, and in partnership with the client or legally responsible person or both, within 30 days of admission for clients who are expected to receive services beyond 30 days. (d) The plan shall include: (1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement; (2) strategies; (3) staff responsible; (4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both; (5) basis for evaluation or assessment of outcome achievement; and (6) written consent or agreement by the client or responsible party, or a written statement by the provider stating why such consent could not be obtained. This Rule is not met as evidenced by: Based on record reviews and interview, the facility failed to have a Person Centered Plan with written consent or agreement by the client or responsible party, or a written statement by the provider stating why such consent could not be	V 112		

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V 112	Continued From page 4 obtained affecting three of three audited clients (#1, #2 and #3). The findings are: Review on 1/9/19 of Client #1's record revealed the following: -Admission date of 11/25/16. -Diagnoses of Chronic Paranoid Schizophrenia, Personality Disorder, Asthma, Sleep Apnea, Type 2 Diabetes, Hypertension, Hypothyroidism. -Client #1 had a Person Centered Plan dated 1/25/17. -Client #1's Person Centered Plan had expired over a year ago. Review on 1/9/19 of Client #2's record revealed the following: -Admission date of 1/13/17. -Diagnoses of Schizophrenia' Intellectual Delay, Cannabis Use Disorder, Alcohol Use Disorder, Hypertension. -Client #2 had a Person Centered Plan dated 2/12/17. -Client #2's Person Centered Plan had expired over a year ago. Review on 1/9/19 of Client #3's record revealed the following: -Admission date of 1/31/17. -Diagnoses of Schizoaffective Disorder, Depressed Type, Bipolar Affective Disorder, Attention Deficit Hyperactivity Disorder, Autistic Disorder, GERD. -Client #3 had a Person Centered Plan dated 10/1/17. -Client #3's Person Centered Plan had expired over a year ago. Interview on 1/9/19 with the Owner/Director revealed: -The Qualified Professional was responsible for	V 112		

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V 112	Continued From page 5 completing the Person Center Plans. -Person Center Plans for Clients #1, #2 and #3 were updated recently, but had not been signed by the clients yet. -Person Centered Plans were at the office. -He would bring Person Centered Plans for Clients #1, #2 and #3 and have them sign it. -He confirmed that the Person Centered Plans for Clients #1, #2, and #3 had no updated Person Centered Plans in their charts.	V 112		
V 114	27G .0207 Emergency Plans and Supplies 10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES (a) A written fire plan for each facility and area-wide disaster plan shall be developed and shall be approved by the appropriate local authority. (b) The plan shall be made available to all staff and evacuation procedures and routes shall be posted in the facility. (c) Fire and disaster drills in a 24-hour facility shall be held at least quarterly and shall be repeated for each shift. Drills shall be conducted under conditions that simulate fire emergencies. (d) Each facility shall have basic first aid supplies accessible for use. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to conduct fire and disaster drills under conditions that simulate emergencies at least quarterly. The findings are: Record review on 1/9/19 of the facility's fire drill	V 114		

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V 114	Continued From page 6 log revealed the following: -1/3/18- 7:00 PM -1/17/18- 3:00 PM -2/7/18- 8:00 PM -2/24/18- 4:00 PM -3/7/18- 7:00 PM -3/22/18- 5:00 PM -4/11/18- 3:30 PM -4/18/18- 5:00 PM -5/9/18- 4:00 PM -5/22/18- 6:00 PM -6/6/18- 3:00 PM -June/BLANK/18- 6:00 PM -July/BLANK/18- 6:00 PM -There were no fire drills conducted for the 4th quarter of 2018. Record review on 1/9/19 of the facility's disaster drill log revealed the following: -1/6/18- 11:00 AM -1/20/18- 4:34 PM -There were no disaster drills conducted for the 2nd, 3rd and 4th quarter of 2018. Interview with client #1 on 3/2/18 revealed: -The group home staff did fire drills with them. -He was not sure how often the fire and disaster drills were conducted. Interview with the Owner/Director revealed: -Facility operates under one shift. -He confirmed staff failed to conduct fire and disaster drills under conditions that simulate emergencies at least quarterly.	V 114		
V 536	27E .0107 Client Rights - Training on Alt to Rest. Int. 10A NCAC 27E .0107 TRAINING ON	V 536		

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V 536	Continued From page 7 ALTERNATIVES TO RESTRICTIVE INTERVENTIONS (a) Facilities shall implement policies and practices that emphasize the use of alternatives to restrictive interventions. (b) Prior to providing services to people with disabilities, staff including service providers, employees, students or volunteers, shall demonstrate competence by successfully completing training in communication skills and other strategies for creating an environment in which the likelihood of imminent danger of abuse or injury to a person with disabilities or others or property damage is prevented. (c) Provider agencies shall establish training based on state competencies, monitor for internal compliance and demonstrate they acted on data gathered. (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 wishes to employ must be approved by the Division of MH/DD/SAS pursuant to Paragraph (g) of this Rule. (g) Staff shall demonstrate competence in the following core areas: (1) knowledge and understanding of the people being served; (2) recognizing and interpreting human behavior; (3) recognizing the effect of internal and external stressors that may affect people with	V 536		

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V 536	Continued From page 8 disabilities; (4) strategies for building positive relationships with persons with disabilities; (5) recognizing cultural, environmental and organizational factors that may affect people with disabilities; (6) recognizing the importance of and assisting in the person's involvement in making decisions about their life; (7) skills in assessing individual risk for escalating behavior; (8) communication strategies for defusing and de-escalating potentially dangerous behavior; and (9) positive behavioral supports (providing means for people with disabilities to choose activities which directly oppose or replace behaviors which are unsafe). (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 Qualifications 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 a passing grade on testing in an instructor training program. (3) The training shall be competency-based, include measurable learning	V 536		

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objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course.
(4) 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 (i)(5) of this Rule.
(5) Acceptable instructor training programs shall include but are not limited to presentation of:
(A) understanding the adult learner;
(B) methods for teaching content of the course;
(C) methods for evaluating trainee performance; and
(D) documentation procedures.
(6) Trainers shall have coached experience teaching a training program aimed at preventing, reducing and eliminating the need for restrictive interventions at least one time, with positive review by the coach.
(7) Trainers shall teach a training program aimed at preventing, reducing and eliminating the need for restrictive interventions at least once annually.
(8) Trainers shall complete a refresher instructor training at least every two years.
(j) Service providers shall maintain documentation of initial and refresher instructor 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 attended; and
(C) instructor's name.
(2) The Division of MH/DD/SAS may request and review this documentation any time.
(k) Qualifications of Coaches:
(1) Coaches shall meet all preparation

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V 536	Continued From page 10 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. (l) Documentation shall be the same preparation as for trainers. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure two of three audited staff (Staff #1 and Owner/Director) had current training in the use of alternatives to restrictive interventions. The findings are: Review of Staff #1's personnel records on 1/9/19 revealed: -Staff #1 had a hire date of 10/10/17. -Staff #1 was hired as a Paraprofessional: Habilitation Technician. -Documentation of Training on Alternatives to Restrictive Intervention expired on October 10, 2018. Review of the Owner/Director's personnel records on 1/9/19 revealed: -Staff #2 had a hire date of 10/10/17. -Staff #2 was hired as a Owner/Director. -Documentation of training on Alternatives to Restrictive Intervention expired on October 10, 2018. Interview on 1/9/19 with the Owner/Director	V 536		

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V 536	Continued From page 11 revealed: -The group home was using the Evidence Based Practice Institute - EBPI Basic Plus training. -He worked at the group home doing many tasks besides being the Owner/Director. -Staff #1 and himself were scheduled to receive their trainings on Alternatives to Restrictive Intervention. -He confirmed Staff #1 and himself did not have current training on Alternatives to Restrictive Intervention.	V 536		