STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
ANDILAN	SI GORREOTION	IDENTIFICATION NOMBER.	A. BUILDING:	A. BUILDING:		
		MHL092-698	B. WING		R 04/09/2019	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ODRESS, CITY, STATE	, ZIP CODE		
MONTRE	AL COURT HOME	303 NOR CARY, N	TH MONTREAL CO C 27511	OURT		
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE	
V 000	INITIAL COMMENTS		V 000			
	on 04-09-19. Deficier This facility is license category: 10A NCAC	d up survey was completed ories were citied d for the following service 27G .5600C Supervised Developmental Disabilities.				
V 118	_	·	V 118			
	10A NCAC 27G .0209 MEDICATION REQUIREMENTS (c) Medication administration: (1) Prescription or non-prescription drugs shall only be administered to a client on the written order of a person authorized by law to prescribe drugs. (2) Medications shall be self-administered by clients only when authorized in writing by the client's physician. (3) Medications, including injections, shall be administered only by licensed persons, or by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer medications. (4) A Medication Administration Record (MAR) of all drugs administered to each client must be kept current. Medications administered shall be recorded immediately after administration. The MAR is to include the following: (A) client's name; (B) name, strength, and quantity of the drug; (C) instructions for administering the drug; (D) date and time the drug is administering the drug. (5) Client requests for medication changes or checks shall be recorded and kept with the MAR file followed up by appointment or consultation with a physician.					

Division of Health Service Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL092-698	B. WING		R <b>04/09/2019</b>
					04/09/2019
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA		
MONTREA	AL COURT HOME	303 NORT CARY, NO	TH MONTREAL	COURT	
(V4) ID	SLIMMARY STA	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTION	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE
V 118	Continued From page	:1	V 118		
V 536	failed to ensure only (#1)) were trained by qualified personnel pr medications. The find  Review on 04-03-19 revealed	ew and interview the facility staff (1 of 3 audited staff a nurse pharmacist or other ior to administering ings are:  of staff #1 personnel record  18 cation administration 9 n 04-04-19, Staff #1 iffied as a medication equirement for adult care a meet the rule requirement  ats - Training on Alt to Rest.  TRAINING ON RESTRICTIVE  blement policies and size the use of alternatives	V 536		

Division of Health Service Regulation

STATE FORM 6899 O4W411 If continuation sheet 2 of 10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
MHL092-698		B. WING		R <b>04/09/2019</b>	
NAME OF PROVIDER OR SUPPLIER		RESS, CITY, STA	TE, ZIP CODE	,	
MONTREAL COURT HOME	303 NORTH CARY, NC	MONTREAL	COURT		
PREFIX (EACH DEFICIENCY N	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
or injury to a person wit property damage is preincompliance and demongathered.  (d) The training shall be include measurable lear measurable testing (write behavior) on those objet methods to determine procurse.  (e) Formal refresher training provider wishes to employ the Division of MH/DD/S Paragraph (g) of this Ru (g) Staff shall demonstrate following core areas:  (1) knowledge and people being served;  (2) recognizing and behavior;  (3) recognizing the external stressors that redisabilities;  (4) strategies for relationships with person (5) recognizing of organizational factors the disabilities;  (6) recognizing the assisting in the person's decisions about their life.	imminent danger of abuse th disabilities or others or evented. In the shall establish training encies, monitor for internal astrate they acted on data the competency-based, arning objectives, itten and by observation of ectives and measurable coassing or failing the earling must be completed er periodically (minimum and that the service alloy must be approved by SAS pursuant to the end understanding of the end understanding of the effect of internal and may affect people with the building positive ons with disabilities; ultural, environmental and that may affect people with the importance of and involvement in making	V 536			

Division of Health Service Regulation

STATE FORM 6899 O4W411 If continuation sheet 3 of 10

DIVISION	n nealth Service Regu	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SUR	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
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		MHL092-698	B. WING		04/09/2	2019
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, STA	TE ZIP CODE		
TO THE OT THE	NOVIBER OR OUT FIER		, ,	,		
MONTREA	MONTREAL COURT HOME 303 NORT			COURT		
		CARY, NC	27511			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE DATE
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				,		
V 536	Continued From page	e 3	V 536			
		tion strategies for defusing				
		tentially dangerous behavior;				
	and					
		navioral supports (providing				
		n disabilities to choose				
	activities which direct					
	behaviors which are u					
	(h) Service providers					
		al and refresher training for				
	at least three years.					
	(1) Documenta	tion shall include:				
	(A) who particip	ated in the training and the				
	outcomes (pass/fail);					
		vhere they attended; and				
	(C) instructor's	name;				
	(2) The Division	n of MH/DD/SAS may				
	review/request this do	ocumentation at any time.				
	(i) Instructor Qualifica	ations and Training				
	Requirements:					
	(1) Trainers sha	all demonstrate competence				
	by scoring 100% on to	esting in a training program				
	aimed at preventing,	reducing and eliminating the				
	need for restrictive inf	terventions.				
	(2) Trainers sha	all demonstrate competence				
	by scoring a passing	grade on testing in an				
	instructor training pro					
	(3) The training					
		nclude measurable learning				
	objectives, measurable testing (written and by					
		or) on those objectives and				
		to determine passing or				
	failing the course.	1 5 -				
	•	t of the instructor training the				
	service provider plans					
		sion of MH/DD/SAS pursuant				
	to Subparagraph (i)(5					
		instructor training programs				
		not limited to presentation of:				
		ng the adult learner;				
	(7.1) anderstanding	ing and additional flot,	1		1	

Division of Health Service Regulation

STATE FORM 6899 O4W411 If continuation sheet 4 of 10

Division of fleatin Service Regulation					[	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
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		MIII 000 C00	B. WING			
		MHL092-698			04/09/2019	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
			H MONTREAL			
MONTRE	AL COURT HOME			COOKI		
		CARY, NC	2/511			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	( - )	
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	<u> </u>	
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IAIE	
				,		
V 536	Continued From page	e 4	V 536			
		teaching content of the				
	course;					
		r evaluating trainee				
	performance; and					
	(D) documentati	ion procedures.				
	(6) Trainers sha	all have coached experience				
	teaching a training pro	ogram aimed at preventing,				
	reducing and eliminat	ing the need for restrictive				
		one time, with positive				
	review by the coach.	•				
	_	all teach a training program				
		reducing and eliminating the				
		erventions at least once				
	annually.	civertions at least office				
	-	all complete a refresher				
	instructor training at le					
	(j) Service providers					
		al and refresher instructor				
	training for at least the					
	` '	entation shall include:				
		ated in the training and the				
	outcomes (pass/fail);					
	· ·	here attended; and				
	(C) instructor's					
	\ <i>\</i>	n of MH/DD/SAS may				
		is documentation any time.				
	(k) Qualifications of C	Coaches:				
	(1) Coaches shall meet all preparation					
	requirements as a tra	iner.				
	(2) Coaches sh	all teach at least three times				
	the course which is be	eing coached.				
		all demonstrate				
	competence by comp	letion of coaching or				
	train-the-trainer instru	<u> </u>				
		all be the same preparation				
	as for trainers.	a 20 the came proparation				
	ao ioi daliloio.					

Division of Health Service Regulation

STATE FORM 6899 O4W411 If continuation sheet 5 of 10

MHL092-698  B. WING	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE		
	PROVIDER OR SUPPLIER	
MONTREAL COURT HOME 303 NORTH MONTREAL COURT	AL COURT HOME	
CARY, NC 27511	ALCOOKTHOME	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X COMMEDIA	(EACH DEFICIENCY MUST BE PRECEDED BY FULL	
V 536 Continued From page 5 V 536	Continued From page 5	
This Rule is not met as evidenced by: Based on record review and interview 1 of 3 audited staff (#2) failed to maintain annual training in alternatives to restrictive interventions. The findings are:  Review on 04-03-19 of staff #2's personnel record revealed:  - Hire date May 2014  - NCI training expired January 2019  During interview on 04-04-19, Staff #2 reported that she is signed up for a training the following week however, her NCI training is expired.  During interview on 04-03-19 with the Human Resource Director she stated that Staff #2's training had expired January 2019.  V 537  27E .0108 Client Rights - Training in Sec Rest & ITO  10A NCAC 27E .0108 TRAINING IN SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT (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	Based on record review audited staff (#2) failed to training in alternatives to The findings are:  Review on 04-03-19 of secord revealed:  - Hire date May 201 - NCI training expired  During interview on 04-00 that she is signed up for week however, her NCI  During interview on 04-00 Resource Director she set training had expired Jan  7 27E .0108 Client Rights ITO  10A NCAC 27E .0108 SECLUSION, PHYSICA ISOLATION TIME-OUT (a) Seclusion, physical time-out may be employ been trained and have do competence in the properto these procedures. Fastaff authorized to employ procedures are retrained competence at least and (b) Prior to providing directions.	

Division of Health Service Regulation

STATE FORM 6899 O4W411 If continuation sheet 6 of 10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
THE PERIOD CONTROL OF THE	IDEIVII IO/MICK NOMBEIX	A. BUILDING: _		OOMI EETEB	
		D. MAINIO		R	
	MHL092-698	B. WING		04/09/2019	
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
MONTREAL COURT HOME	303 NORT	H MONTREAL	COURT		
MONTREAL GOOK! HOME	CARY, NO	27511			
PREFIX (EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
V 537 Continued From page	e 6	V 537			
includes restrictive int service providers, em volunteers shall compseclusion, physical re and shall not use thes training is completed demonstrated.  (c) A pre-requisite for demonstrating competraining in preventing, the need for restrictive (d) The training shall include measurable lemeasurable testing (where the behavior) on those observation on those observation of the training provider plans to empthe Division of MH/DE Paragraph (g) of this (g) Acceptable training but are not limited to, (1) refresher into the use of restrictive in (2) guidelines of (3) emphasis of (4) strategies for of restrictive interventions.	ployees, students or oblete training in the use of straint and isolation time-out se interventions until the and competence is a taking this training is stence by completion of reducing and eliminating e interventions. Se competency-based, earning objectives, written and by observation of objectives and measurable e passing or failing the extraining must be completed der periodically (minimum aning that the service obloy must be approved by O/SAS pursuant to Rule.  In g programs shall include, presentation of: formation on alternatives to interventions; on when to intervene lent danger to self and an intervention; or the safe implementation or the safe implementation.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
			B. WING		R	
		MHL092-698	B. WING	······	04/09/2019	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		303 NOR	TH MONTREAL	COURT		
MONTRE	MONTREAL COURT HOME CARY, NO					
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD	( - )	
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17.0		,	IAG	DEFICIENCY)		
V 537	Continued From page	e 7	V 537			
	assessment and mon	nitoring of the physical and				
		ing of the client and the safe				
		ghout the duration of the				
	restrictive intervention	-				
	(6) prohibited p					
	1	strategies, including their				
	importance and purpo					
		tion methods/procedures.				
	(h) Service providers					
		ial and refresher training for				
	at least three years.	Control of the contro				
	` '	tion shall include:				
	· · · · · · · · · · · · · · · · · · ·	ated in the training and the				
	outcomes (pass/fail);					
		vhere they attended; and				
	(C) instructor's					
		n of MH/DD/SAS may				
	_ ·	ocumentation at any time.				
	(i) Instructor Qualification	ation and Training				
	Requirements:					
		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				
		esting in a training program				
	teaching the use of se	eclusion, physical restraint				
	and isolation time-out	t.				
	(3) Trainers sha	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 sotorimino paccing or				
		t of the instructor training the				
	service provider plans					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
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		MHL092-698	B. WING		R <b>04/09/2019</b>	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
MONTRE	AL COURT HOME	303 NORTI	H MONTREAL	COURT		
MONTKE	AL GOOK! HOME	CARY, NC	27511			
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
V 537	Continued From page	e 8	V 537			
V 537	approved by the Divisito Subparagraph (j)(6) (6) Acceptable shall include, but not of: (A) understanding the weak of the course; (C) evaluation of the course of t	sion of MH/DD/SAS pursuant b) of this Rule. instructor training programs be limited to, presentation  Ing the adult learner; In teaching content of the  of trainee performance; and ion procedures. In the retrained at least strate competence in the use I restraint and isolation I in Paragraph (a) of this  I all be currently trained in  I have coached experience I restrictive interventions at I positive review by the  I complete a refresher I east every two years. I shall maintain I all and refresher instructor I ree years. I tion shall include: I ated in the training and the  I where they attended; and	V 537			
	review/request this do	ocumentation at any time. Coaches:				
	(1) Coaches sh requirements as a tra	nall meet all preparation iner.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		MHL092-698	B. WING	<del></del>	04	R <del>/<b>09/2019</b></del>
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STAT	E, ZIP CODE		
MONTRE	AL COURT HOME		RTH MONTREAL C	OURT		
	T		NC 27511			
(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 C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
V 537	Continued From page	9	V 537			
	times, the course whi	nall demonstrate eletion of coaching or ection. Shall be the same				
	audited staff (#2) failed training in selculion policy isolation time out. The Review on 04-03-19 of record revealed:  - Hire date May 2	ew and interview 1 of 3 ed to maintain annual hysical restraint and e findings are : of staff #2's personnel				
	During interview on 0 that she is signed up week however, her N	4-04-19 Staff #2 reported for a training the following CI training is expired. 4-03-19 with the Human e stated that Staff #2's				

Division of Health Service Regulation

STATE FORM 6899 O4W411 If continuation sheet 10 of 10