AND DIAN OF CORRECTION INDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			X3) DATE SURVEY COMPLETED	
		MHL001-257	B. WING		05/0	8/2019
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
LEVAN P	PLACE III		RA AVENUE			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	BURLINGTON, NC 27215  ID PROVIDER'S PLAN OF CORRECTION (X5)			(X5)
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	COMPLETE DATE
V 000	INITIAL COMMENT	-s	V 000			
	An annual survey w Deficiencies were c	ras completed on May 8, 2019. ited.				
	category: 10A NCA	sed for the following service C 27G .5600C Supervised h Developmental Disabilities.				
V 112	27G .0205 (C-D) Assessment/Treatn	nent/Habilitation Plan	V 112			
	TREATMENT/HABI PLAN  (c) The plan shall be assessment, and in legally responsible pof admission for clie receive services be (d) The plan shall in (1) client outcome (achieved by provision projected date of acceptance (2) strategies;  (3) staff responsible (4) a schedule for annually in consultar responsible person (5) basis for evaluation outcome achievement (6) written consent responsible party, or	nclude: s) that are anticipated to be on of the service and a chievement; e; review of the plan at least ation with the client or legally or both; ation or assessment of				

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

TITLE (X6) DATE

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		MHL001-257	B. WING		05/0	08/2019	
	LEVAN PLACE III. 1622 FLO		DRESS, CITY, S RA AVENUE TON, NC 27				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETE DATE	
V 112	This Rule is not me Based on record re facility failed to haw written consent or a responsible party, oprovider stating why obtained affecting ti (#1, #2 and #3). The Review on 5/8/19 of the following:  -Admission date of -Diagnosis of Intelles Severe.  -Client #1's Person -Client #1 had trans 1/1/19.  -There was no evid Centered Plan had Review on 1/9/19 of the following:  -Admission date of -Diagnoses of Impulatellectual Impairm Disorder; Hypertens Disease.  -Client #2 had a Pe 9/5/17  -Client #2 had trans 1/1/19.  -There was no evid Centered Plan had Review on 1/9/19 of the following:  -Admission date of -Diagnosis of Autistic Centered Plan had Review on 1/9/19 of the following:  -Admission date of -Diagnosis of Autistic Centered Plan had Review on 1/9/19 of the following:	et as evidenced by: views and interview, the e a Person Centered Plan with agreement by the client or or a written statement by the y such consent could not be hree of three audited clients e findings are:  If Client #1's record revealed  8/3/10. Ectual Disability, Moderate to Centered Plan had expired. If erred from sister facility on ence that a new Person been completed.  If Client #2's record revealed  7/15/15. Ilsive Control Disorder; Itent; Cognitive behavior Ision; Hypersensitive Lung Irson Centered Plan dated  If erred from sister facility on ence that a new Person been completed.  If Client #3's record revealed  If Client #3's record revealed  If Client #3's record revealed  If Client #3's record revealed	V 112				

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STATE FORM 6899 03G711 If continuation sheet 2 of 7

Division of Health Service Regulation
STATEMENT OF DEFICIENCIES (X1) PROV

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		l` 'COM		(X3) DATE COMP	SURVEY LETED
		A. BUILDING:			
MHL001-257		B. WING		05/0	8/2019
NAME OF PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
LEVAN PLACE III		RA AVENUE TON, NC 27			
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
1/1/19There was no evide Plan had been complan had been completing training of the restrictive intervel (b) Prior to providin disabilities, staff inclemployees, students demonstrate compectomperty damage is (c) Provider agencibased on state comcompliance and der gathered. (d) The training shall in practice intervel (b) Prior to providing the strategies for which the likelihood or injury to a person property damage is (c) Provider agencibased on state comcompliance and der gathered. (d) The training shall	ferred from sister facility on ence that a Person Centered pleted.  with the Director/Qualified ed: ble for completing the Person cess of updating the Person Clients #1, #2 and #3.  Clients #1, #2, and #3 had no ntered Plans in their charts.  ghts - Training on Alt to Rest.  O7 TRAINING ON DRESTRICTIVE  mplement policies and easize the use of alternatives ntions.  In g services to people with luding service providers, sor volunteers, shall etence by successfully in communication skills and creating an environment in of imminent danger of abuse in with disabilities or others or	V 112			

Division of Health Service Regulation

STATE FORM 6899 03G711 If continuation sheet 3 of 7

NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  1622 FLORA AVENUE BURLINGTON, NC 27215    (X4) ID   PREFIX TAG   (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG   (EACH DEFICIENCY) PREFIX TAG   (EACH DEFICIENCY) PROVIDERS PLAN OF CORRECTION (MS)   (EACH DEFICIENCY) PREFIX TAG   (EACH DEFICIENCY) PROVIDERS PLAN OF CORRECTION (MS)   (EACH DEFICI			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
NAME OF PROVIDER OR SUPPLIER  LEVAN PLACE III  SUMMARY STATEMENT OF DEFICIENCY NO. NC. 27215  (X4) ID PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  V 536  Continued From page 3  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 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 disabilities;			MHL001-257	B. WING		05/08/2019	
CVA   ID PREFIX TAGE   III   SUMMARY STATEMENT OF DEFICIENCIES   PREFIX TAGE   PROVIDER'S PLAN OF CORRECTION   PREFIX TAGE   PROVIDER'S PLAN OF CORRECTION   PREFIX TAGE   PROVIDER'S PLAN OF CORRECTION   PREFIX TAGE   PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE   COMPLETE DATE      V 536   Continued From page 3   V 536      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 disabilities;	NAME OF I	PROVIDER OR SUPPLIER		L			
X4) ID   SUMMARY STATEMENT OF DEFICIENCIES   PREFIX TAG   REGULATORY OR LSC IDENTIFYING INFORMATION)   PREFIX TAG   PREF							
PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  V 536  Continued From page 3  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 disabilities;	LEVAN F	PLACE III	BURLING	TON, NC 27	215		
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 disabilities;	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	.D BE	COMPLETE
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 disabilities;	V 536	Continued From pa	ge 3	V 536			
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		measurable testing behavior) on those methods to determicourse.  (e) Formal refreshed by each service proannually).  (f) Content of the transport of the Division of MH/I/Paragraph (g) reading server (2) recognizing behavior;  (3) recognizing external stressors to disabilities;  (4) strategies relationships with proganizational factor disabilities;  (6) recognizing organizational factor disabilities;  (6) recognizing assisting in the person decisions about the (7) skills in assescalating behavior (8) communication de-escalating pand  (9) positive behaviors which direst behaviors which are	(written and by observation of objectives and measurable ine passing or failing the er training must be completed ovider periodically (minimum raining that the service employ must be approved by DD/SAS pursuant to is Rule.  Constrate competence in the est eand understanding of the ed; ing and interpreting human and that may affect people with the for building positive ersons with disabilities; ing cultural, environmental and for that may affect people with the importance of and son's involvement in making ir life; is sessing individual risk for its cation strategies for defusing obtentially dangerous behavior; ehavioral supports (providing with disabilities to choose ctly oppose or replace e unsafe).				

Division of Health Service Regulation

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COMPLETED		
		MHL001-257	B. WING		05/0	8/2019
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
. =\(\alpha\)	N 405 III	1622 FLO	RA AVENUE			
LEVAN P	LACE III	BURLING	TON, NC 27	215		
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO		COMPLETE DATE
IAG	NEGGE WORT ON E		IAG	DEFICIENCY)		
V 536	Continued From pa	ae 4	V 536			
	·					
	at least three years	tation shall include:				
	<b>\</b> /	sipated in the training and the				
	outcomes (pass/fail					
		where they attended; and				
	(C) instructor					
		ion of MH/DD/SAS may				
	<b>\</b> /	documentation at any time.				
		ications and Training				
	Requirements:					
		shall demonstrate competence				
		testing in a training program				
	aimed at preventing, reducing and eliminating the					
	need for restrictive interventions.					
		shall demonstrate competence				
	instructor training p	g grade on testing in an				
		ng shall be				
		, include measurable learning				
		able testing (written and by				
		avior) on those objectives and				
		ds to determine passing or				
	failing the course.					
	(4) The conte	ent of the instructor training the				
		ans to employ shall be				
		vision of MH/DD/SAS pursuant				
	to Subparagraph (i)					
		le instructor training programs				
		e not limited to presentation of:				
		ding the adult learner; for teaching content of the				
	course;	To teaching content of the				
	•	for evaluating trainee				
	performance; and	101 Ordinating trained				
		ation procedures.				
	` ,	shall have coached experience				
		program aimed at preventing,				
		nating the need for restrictive				
		st one time, with positive				

Division of Health Service Regulation STATE FORM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	MHL001-257		B. WING		05/0	8/2019
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	•	
LEVAN F	PLACE III		RA AVENUE TON, NC 27			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
V 536	aimed at preventing need for restrictive annually.  (8) Trainers sinstructor training a (j) Service provided documentation of intraining for at least (1) Documentation outcomes (pass/fai (B) when and (C) instructor (2) The Division request and review (k) Qualifications of (1) Coaches requirements as a formal (2) Coaches the course which is (3) Coaches competence by contrain-the-trainer instructions.	ch. Shall teach a training program g, reducing and eliminating the interventions at least once shall complete a refresher t least every two years. rs shall maintain nitial and refresher instructor three years. mentation shall include: cipated in the training and the l); d where attended; and d's name. ion of MH/DD/SAS may this documentation any time. of Coaches: shall meet all preparation trainer. shall teach at least three times being coached. shall demonstrate mpletion of coaching or	V 536			
	failed to ensure two current training on	et as evidenced by: view and interview, the facility of two staff (#1 and #2) had the use of alternatives to ions prior to providing				

services. The findings are:
Division of Health Service Regulation

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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		
	MHL001-257 B. WING		05/08/2019			
			DRESS, CITY, S	STATE, ZIP CODE		
LEVAN F	PLACE III		TON, NC 27			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
V 536	Continued From pa	ge 6	V 536			
	Professional record -Hire date of 3/18/1 -She was hired as a ProfessionalTraining on alterna had expired on 3/2/ Review on 5/8/19 or revealed: -Hire date of 4/21/1 -Staff #2 was hired -Training on alterna had expired on 3/2/ Interview on 5/7/19 Professional reveal -The group home h -Group home only a restrictive interventi -Agency used NCI curriculum for altern interventionsThe Director/Quali were scheduled to a to restrictive interveShe confirmed Sta	4. a Director/Qualified atives to restrictive intervention 19. If Staff #2's personnel records 1. as a Direct Care Staff. atives to restrictive intervention 19. If the Director/Qualified ed: ad a "no hands on" policy. Applied alternatives to ions. Interventions as training natives to restrictive fied Professional and Staff #2 attend training on alternatives entions on 6/1/19. If #2 and her did not have the use of alternatives to				

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