	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:  B. WING			(X3) DATE SURVEY COMPLETED  R 05/07/2019	
17		MHL051-138					
NAME OF PE	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STATE	E, ZIP CODE			
THE LIGH	THOUSE II OF CLAYTO	2016 FOR					
		CLAYTON	, NC 27520				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLET DATE	
V 000	INITIAL COMMENTS	3	V 000				
ál As		r-up survey was completed re were deficiencies cited.					
1.e	category: 10A NCAC	ed for the following service 27G. 1700 nt Staff Secure for Children					
Fri	or Adolescents	it otali occure for official		DHSR - Menta	I Health		
V 113	27G .0206 Client Re-	cords	V 113	MAY 162	019	1770	
	(a) A client record sh individual admitted to contain, but need not	ace sheet which includes:		Lic. & Cert. S	Section		
	<ul><li>(B) client record num</li><li>(C) date of birth;</li><li>(D) race, gender and</li><li>(E) admission date;</li><li>(F) discharge date;</li><li>(2) documentation of</li></ul>	marital status;					
	developmental disab diagnosis coded acco (3) documentation of assessment;	ilities or substance abuse ording to DSM IV; the screening and					
	shall include the nam number of the persor	nation for each client which e, address and telephone n to be contacted in case of					
	<ul><li>and telephone number</li><li>physician;</li><li>(6) a signed statement</li></ul>	ident and the name, address er of the client's preferred nt from the client or legally					
	emergency care from (7) documentation of	ranting permission to seek a hospital or physician; services provided; progress toward outcomes;					
vision of Heal	(9) if applicable:						
		SUPPLIER REPRESENTATIVE'S SIGNATURE	D.	TITLE of Operations	5	(X6) DATE	
ATE FORM	• • •		6899 WQ	29611	If continu	ation sheet 1	

Division	of Hoolth Coming Dogs	dation			FORM APPROVED
	of Health Service Regult of Deficiencies	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
					R
		MHL051-138	B. WING		05/07/2019
NAME OF D	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	ZIP CODE	1845
NAIVIE OF P	ROVIDER OR SUPPLIER		ORT DRIVE	, 211 0002	
THE LIGH	ITHOUSE II OF CLAYTON		ON, NC 27520		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF COR	RRECTION (X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLETE
V 113	Continued From page	e 1	V 113		- 1 APPRO- 8.3
57)	(A) documentation of	physical disorders			1.50 (2.5)
61.5		o International Classification			
Fy:	of Diseases (ICD-9-C				
	(B) medication orders				110
in Masser (in)	(C) orders and copies				l Andrew
	(D) documentation of				
135		and adverse drug reactions. ensure that information			
		ated conditions is disclosed			
	only in accordance wi				
		ified in G.S. 130A-143.			
	**************************************				
			7		
	This Rule is not met a	as evidenced by:			
		ews and interview, the			
		e admission information was			
	completed for one of t				
		were documented and filed			
	for 4 of 4 clients (#1, #	#2, #3, #4). The findings			
	are:				
	A. Review on 5/7/19 o	of Client #3's record			
	revealed:	or Cheft #3 s record			
	-There was no admiss	sion date.			
	-Diagnoses of Conduc	ct Disorder, Unspecified			
		od Dysregulation Disorder,			
		with Mixed Emotions and			
	Attention Deficit Hype				
	the client's record.	ing and/or assessment in			15
	the chefit's record.				
	Interview on 5/7/19 wi	th the Clinical Director			
	revealed:				
	-Confirmed client #3 a	admission date and			
	assessment was not i				
		ner program director might			
	have the assessment	on his computer.			

Division of Health Service Regulation (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: R B. WING 05/07/2019 MHL051-138 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2016 FORT DRIVE THE LIGHTHOUSE II OF CLAYTON CLAYTON, NC 27520 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) V 113 V 113 Continued From page 2 -Reported client #3 was admitted in September B. Review on 5/7/19 of the Facility File for Clinical Notes revealed: -The file provided group notes documented by the Qualified Professionals. -There were no therapy notes for Client #1, Client #2, Client #3 and Client #4. Interview on 5/7/19 with the Clinical Director revealed: -Worked with the company since 2015 and recently promoted to Clinical Director. -She was the contract therapist for the clients prior to the Clinical Director position. -She provided therapy 2x/week for 4 hours per week. -She provided individual therapy. -Therapy notes were written down in her notebook. -She confirmed there were no typed therapy -She was unable to produced therapy notes. Interview on 5/7/19 with the Director of Operations revealed: -Former program director maintained client records. -Former program director resigned about one week ago. -Staff in the process of organizing client records and obtaining any documentation from former staff. -The clinical director was required to provide individual therapy to clients weekly. -Clinical director was required to meet clients 2x/week for 4 hours per week. -Confirmed there was no evidence of therapy

notes.

Division of Health Service Regulation

1		1-6			FC	RM APPROVED
	of Health Service Requirt of DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	[(X3) DA	TE SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		Accessed to the contract of th	MPLETED
						R
		MHL051-138	B. WING		C	5/07/2019
	200//050 00 01/00//50	CTOSET /	ADDRESS, CITY, STATE	ZID CODE		
NAME OF F	PROVIDER OR SUPPLIER			E, ZIP CODE		
THE LIGH	THOUSE II OF CLAYTON	J	ORT DRIVE ON, NC 27520			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF COR	RRECTION	(X5)
TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)		COMPLETE
						90(2.50
V 536	S 27F 0107 Client Righ	nts - Training on Alt to Rest.	V 536			
S.	Int.	its - Training of the to rest.				
	inc.					
	10A NCAC 27E .0107	TRAINING ON				
	ALTERNATIVES TO I	RESTRICTIVE				Harring
h f n ,	INTERVENTIONS					
N/A	(a) Facilities shall im					
TE		size the use of alternatives				
PROFESSOR	to restrictive intervent					
	The state of the s	services to people with ding service providers,				
	employees, students					
******	demonstrate compete					6 (Cara ) (1)
	그렇게 하나 아이들이 아이들이 아이들이 얼마나 하는데 그렇게 되었다면 하나 되었다.	communication skills and				
		eating an environment in				
	which the likelihood o	f imminent danger of abuse				
		vith disabilities or others or				
	property damage is p					
		s shall establish training				
		etencies, monitor for internal onstrate they acted on data				
	gathered.	onstrate they acted on data				
FL	-	be competency-based,				
VI.A.	include measurable le					
	measurable testing (w	vritten and by observation of				
		jectives and measurable				
	methods to determine	passing or failing the				
	course.					
		training must be completed			¥;	
	annually).	der periodically (minimum				
	(f) Content of the train	ning that the service				
		ploy must be approved by				
	the Division of MH/DD					
	Paragraph (g) of this I					
	(g) Staff shall demons	strate competence in the				
	following core areas:					
		and understanding of the				
	people being served;	Section 1 to 1				
	(2) recognizing	and interpreting human	1			

Division	of Health Service Requ	ulation			1 0111	MAPPROVED
	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	ETED
					F	₹
	8000a	MHL051-138	B. WING		05/0	07/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	E. ZIP CODE		
IVAIVIL OF T	NO VIDER ON CONTENER		ORT DRIVE			
THE LIGH	THOUSE II OF CLAYTOR	V	ON, NC 27520			
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORF	RECTION	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)		COMPLETE DATE
V 536	Continued From page	e 4	V 536			1 62
Di	1					
	behavior;					
/API		the effect of internal and				
		at may affect people with				
	disabilities; (4) strategies for	or building positive				7759-9
		rsons with disabilities;				
		cultural, environmental and				
Tr		s that may affect people with				
tra sector	disabilities;	•				
	(6) recognizing	the importance of and				
		n's involvement in making				
	decisions about their					
		essing individual risk for				
	escalating behavior;	tion strategies for defining				
		tion strategies for defusing				
	and de-escalating po	tentially dangerous behavior;				
		navioral supports (providing				
		h disabilities to choose				
	activities which direct					
	behaviors which are u					
	(h) Service providers	s shall maintain				
	documentation of initi	ial and refresher training for				
	at least three years.					
		tion shall include:				
		ated in the training and the				
	outcomes (pass/fail);	where they attended; and				
	<ul><li>(B) when and w</li><li>(C) instructor's</li></ul>	AND A STATE OF THE	100			
		n of MH/DD/SAS may				
	10 TO	ocumentation at any time.				
	(i) Instructor Qualifica		1			
	Requirements:					
		all demonstrate competence				
		esting in a training program				
		reducing and eliminating the				1
	need for restrictive int					
		all demonstrate competence				
	by scoring a passing	grade on testing in an				759537

Division	of Health Service Reg	gulation			
STATEMEN"	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
					R
		MHL051-138	B. WING		05/07/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATI	E, ZIP CODE	
		2016 FC	ORT DRIVE		
THE LIGH	THOUSE II OF CLAYTO	ON.	ON, NC 27520		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORREC	TION (X5)
PREFIX		NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	
V 536	Continued From pa	go 5	V 536		486 13
DA	Continued From pa	ge 3			
	instructor training p				
Ast		ng shall be			
		include measurable learning			
		able testing (written and by			319
Here's		avior) on those objectives and			market and the
		ds to determine passing or			
	failing the course.				
		ent of the instructor training the	201		
		ns to employ shall be			
		vision of MH/DD/SAS pursuant			
	to Subparagraph (i)				
		e instructor training programs e not limited to presentation of:			11 MANUAL TO 12 MA
		ding the adult learner;			
		for teaching content of the			- 100 - 100
	course;	for teaching content of the			9.00
		for evaluating trainee			
	performance; and	ior evaluating trainee			
	•	ation procedures.			1 115
		hall have coached experience			
		program aimed at preventing,			
'n		ating the need for restrictive			
		st one time, with positive			
	review by the coach	L <sub>a</sub>	MI I		
	(7) Trainers s	hall teach a training program			
	aimed at preventing	, reducing and eliminating the			
	need for restrictive i	nterventions at least once			
	annually.				4
		hall complete a refresher			
		least every two years.			
	(j) Service provider				and the second
		itial and refresher instructor			200
	training for at least t				
	( )	nentation shall include:			
		ipated in the training and the			
	outcomes (pass/fail)				
	and the second s	where attended; and			and the second s
		on of MH/DD/SAS may			
	(E) THE DIVISION	on or will induitorio may	1		4

Division	of Health Service Regu	lation			FORM APPROVED
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY COMPLETED
		MHL051-138	B. WING		05/07/2019
NAME OF F	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	ZIP CODE	
NAME OF F	ROVIDER OR SUPPLIER		RT DRIVE	., 211 0002	
THE LIGH	ITHOUSE II OF CLAYTON		N, NC 27520		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COP (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLETE
V 536	Continued From page	÷ 6	V 536		1.4628.00.00
<u>Liar</u> s: n	<ul><li>(k) Qualifications of C</li><li>(1) Coaches sh</li></ul>	all meet all preparation			
NA	the course which is be	all teach at least three times			319
T1	competence by comp train-the-trainer instru (I) Documentation sh as for trainers.				
and the second					
	failed to ensure the C two audited staff (#1)	as evidenced by: w and interview the facility linical Director and one of had current training in ve interventions. The			
	Review on 5/7/19 of S revealed: - Hire date: 12/9/17 - Job title: 3rd Shift - PreviousNCI train 1/20/19.	Residential Counselor ing completed 1/20/18 - ent training in alternative to			
	Review on 5/7/19 of the personnel record reverse - Hire date: 8/4/15 Job title: Clinical E - Previous NCI train	aled: Director	7.5 x 3.5 x 5.7		

4/24/18-4/24/19.

	of Health Service Requ		L (YO) MULTIPLE (	ONSTRUCTION	(X3) DA	TE SURVEY	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C		1 (2 (75)	COMPLETED	
			A. BOILDING.			R	
		MHL051-138	B. WING			5/07/2019	
7.7							
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	E, ZIP CODE			
THE LIGH	THOUSE II OF CLAYTON		RT DRIVE				
		CLAYIO	N, NC 27520		2205071011		
PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE	
V 536	Continued From page	e 7	V 536			PROVED	
51	- There was no cur	rent training in alternative to					
Mir.	restrictive intervention		1				
			5				
	Interview on 5/7/19 w	ith the Director of					
****	Operations revealed:	Lillie todie ad an Cofety Core	B-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1				
	to replace NCI.	ld be trained on Safety Care					
The state of the s		orted she started segments	# # 10				
A CAMPACA	of the training.	•	1				
in de	-He would contact the	e trainer to obtain status of	and the second			15,44	
	completion for staff.		The same same				
(main) + To		s no evidence staff had	***			a market seem over the	
	interventions.	ernatives to restrictive	4				
	interventions.						
V 537	27F 0108 Client Righ	nts - Training in Sec Rest &	V 537				
, , ,	ITO	no maning model to					
	10A NCAC 27E .0108						
		CAL RESTRAINT AND					
	ISOLATION TIME-OU	cal restraint and isolation					
		loyed only by staff who have					
	been trained and hav	- 1					
		oper use of and alternatives					
		Facilities shall ensure that					
		nploy and terminate these					
	competence at least	ned and have demonstrated	-				
		direct care to people with					
		atment/habilitation plan					
		terventions, staff including					
	service providers, em						
		plete training in the use of					
		estraint and isolation time-out se interventions until the					
	training is completed						
	demonstrated.						
	(c) A pre-requisite fo	r taking this training is					

STATE FORM

Division	of Health Service Re	gulation				
STATEMEN	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NOWIBER.	A. BUILDING:	and the state of t		
						R
		MHL051-138	B. WING		05	/07/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	E, ZIP CODE		
NAME OF F	ROVIDER OR SOM EIER		ORT DRIVE			
THE LIGH	THOUSE II OF CLAYT	ON	ON, NC 27520			
(V4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT	ION	(X5)
(X4) ID PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOU		COMPLETE DATE
TAG	REGULATORY C	R LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO DEFICIENCY)	PRIAIC	
V 537	Continued From pa	age 8	V 537			
	domanstrating com	petence by completion of				
		ng, reducing and eliminating				
	the need for restric					
		all be competency-based,				
		e learning objectives,				. 113
147.		(written and by observation of				
		objectives and measurable				
Ta.		ine passing or failing the				
to the day into the	course.	3				
		er training must be completed				
		ovider periodically (minimum				
	annually).	*				
	The state of the s	raining that the service				
	provider plans to el	mploy must be approved by				
	the Division of MH/	DD/SAS pursuant to				
	Paragraph (g) of th					
		ning programs shall include,				
	but are not limited t	27				
	( )	information on alternatives to				
	the use of restrictiv	00 Marie - 2 Marie - 2 Marie - 2000 - 2 Marie - 2000 - 2 Marie - 2				
		s on when to intervene				
		ninent danger to self and				
	others);	on safety and respect for the				
		f all persons involved (using				
		estrictive interventions and				
	incremental steps i					
		s for the safe implementation				
	of restrictive interve	and the programme of the control of				
		f emergency safety				
		include continuous				
	assessment and m	onitoring of the physical and				
	psychological well-	being of the client and the safe				
		oughout the duration of the				
	restrictive intervent					
		d procedures;				
		strategies, including their				
	importance and pur					
	(8) documen	tation methods/procedures.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION A BUILDING:  (X3) DATE SURVEY COMPLETED  (X3) DATE SURVEY COMPLETED  (X4) DENTIFICATION NUMBER:  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE DEFICIENCY OR LSC IDENTIFYING INFORMATION)  (X5) CONTINUED FROM PAGE 9  (X6) 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	Division of	of Health Service Reg	ulation				
MHL051-138  STREET-ADDRESS, CITY, STATE, ZIP CODE  2016 FORT DRIVE CLAYTON, NC 27520  THE LIGHTHOUSE II OF CLAYTON  (K4) ID PRETIX PROVIDER OR SUPPLIER  SUMMARY STATEMENT OF DEPTER 0056 SPPILL PRETIX PROVIDER OR SUPPLIER  PRETIX PROVIDER OR SUPPLIER  SUMMARY STATEMENT OF DEPTER 0056 SPPILL PRETIX PROVIDER OR SUPPLIER  PRETIX PROVIDER SPAIN OF CONFIDENCE OR SPPILL PRETIX PROVIDER OR SUPPLIER  PRETIX PROVIDER OR SUPPLIER  PRETIX PROVIDER OR SUPPLIER  PRETIX PROVIDER OR SUPPLIER  PRETIX PROVIDER SPAIN OF CONFIDENCE  PRETIX PROVIDER SPAIN OF CONFIDENCE PRETIX PROVIDENCE SPAIN OF CONFIDENCE PRETIX PROVIDER SPAIN OF CONFIDENCE PRETIX SPAIN OF CONFIDENCE P			(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C			
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS. CITY. STATE, ZIP CODE  2016 FORT DRIVE CLAYTON, NC 27520  THE LIGHTHOUSE IN OF CLAYTON  ((A4) ID  SUMMARY STATEMENT OF DEPICIENCIES  ((EAC) DEPICIENCY MAST OF PRECEDED IN FULL  ((A4) ID  PRETIX ((EAC) DEPICIENCY MAST OF PRECEDED IN FULL  ((A5) DEPICE MAST OF PRECEDED IN FULL  ((A5) DEPICE MAST OF PRECEDED IN FULL  ((A6) Who participated in the training for at least three years.  ((1) Documentation of initial and refresher training for at least three years.  ((2) The Division of MH/DD/SAS may  review/request this documentation at any time.  ((3) Instructor Qualification and Training  Requirements:  (1) Trainers shall demonstrate competence  by scoring 100% on testing in a training program  amed at preventing, reducing and eliminating the  meed for restrictive interventions.  (2) Trainers shall demonstrate competence  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 ()(6) of this Rule.  (8) Methods for teaching content of the  (B) methods for teaching content of the  methods for teaching content of the  methods for teaching content of the	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
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(B) methods for teaching content of the			ting the adult learner:				
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Division of	of Health Service Reg	ulation			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY COMPLETED
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
		1			R
		MHL051-138	B. WING		05/07/2019
-/		OTDEET.	ADDRESS CITY STATE	ZIR CODE	
NAME OF P	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE	E. ZIP CODE	
THE LIGH	THOUSE II OF CLAYTO	N.	ORT DRIVE		
			ON, NC 27520	SPOURERIO DI ANI OF CORRECTION	E /VE)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES  CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	BE COMPLETE
TAG		R LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	RIATE DATE
				DEI IOIERO I	3W 456 C
V 537	Continued From pag	ge 10	V 537		LAF PROFEC
Oh.			4		1.67.77
OT. Ass		n of trainee performance; and attention procedures.			
	· · · · · · · · · · · · · · · · · · ·	hall be retrained at least			
	· /	nstrate competence in the use			
		al restraint and isolation			
147		d in Paragraph (a) of this			
	Rule.	W (81)			
TI:	(8) Trainers s	hall be currently trained in			
Contract	CPR.				
		hall have coached experience			
		of restrictive interventions at			
Control of the Control		a positive review by the			. Contains a labor
	coach.	hall tooch a program on the			
		hall teach a program on the erventions at least once			
	annually.	erventions at least office			
		hall complete a refresher			
		least every two years.			
	(k) Service provider				
	documentation of in	itial and refresher instructor			
	training for at least t				
	` '	ation shall include:			
		pated in the training and the			
	outcome (pass/fail);				
		where they attended; and			
***	(C) instructor'	on of MH/DD/SAS may			
		documentation at any time.			
	(I) Qualifications of				
		shall meet all preparation			
	requirements as a tr				
		shall teach at least three			
		nich is being coached.			
		shall demonstrate			
		pletion of coaching or	1		
	train-the-trainer inst				
	(m) Documentation				
	preparation as for tr	ainers.			

STATE FORM

TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG CROSS-REFERENCED TO THE APPROPRIATE  DATE  DEFICIENCY)	Division of	of Health Service Regu	lation				
NAME OF PROVIDER OR SUPPLIER  THE LIGHTHOUSE II OF CLAYTON  (MA) 0  SUMMARY STATEMENT OF DEFICIENCES  2016 FORT DRIVE CLAYTON, NC 27520   D  PROVIDER'S PLAN OF CORRECTION  REGULATORY OR I.S.D. DENTIFYING INFORMATION)  V \$37  Continued From page 11  V \$37  Continued From page 11  V \$37  This Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure the Clinical Director and one of two audited staff (#1) had training in seclusion, physical restraint and isolation time-out. The finding are:  Review on 5/7/19 of Staff #1's personnel record revealed:  - Hire date: 12/9/17  - Job title: 3'rd Shift Residential Counselor - Previous training NCI completed 1/20/18  - 1/20/19  - There was no current training in seclusion, physical restraint and isolation time-out.  Review on 5/7/19 of the Clinical Director personnel record revealed:  - Hire date: 18/415  - Job title: Olinical Director personnel record revealed:  - Hire date: 18/415  - There was no current training in seclusion, physical restraint and isolation time-out.  Interview on 5/7/19 with the Director of Operations revealed:  - The reads: NO.I.  Interview on 5/7/19 with the Director of Operations revealed:  - The facility staff would be trained on Safety Care to replace NO.I.  Clinical Director reported she started segments of the training.  - He would contact the trainer to obtain status of completion for staff.  - Confirmed there was no evidence staff had	STATEMEN	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA				
THE LIGHTHOUSE II OF CLAYTON  CLAYTON, NO. 27520  TAG  SUMMARY STATEMENT OF DEPICIENCIES  (EACH DEPICIENCY MUST BE PRECEDED BY FULL TAG  REGULATORY OR LSC DENTIFYING INFORMATION)  TAG  This Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure the Climical Director and one of two audited staff (#1) had training in seclusion, physical restraint and isolation time-out. The finding are:  Review on 5/7/19 of Staff #1's personnel record revealed:  - Hire date: 12/9/17  - Job title: 3rd Shiff Residential Counselor - Previous training NCI completed 1/20/18  1/20/19  - There was no current training in seclusion, physical restraint and isolation time-out.  Review on 5/7/19 of the Clinical Director personnel record revealed:  - Hire date: 8/4/15  - Job title: Clinical Director - Previous training NCI completed 4//24/18-4/24/19.  - There was no current training in seclusion, physical restraint and isolation time-out.  Interview on 5/7/19 with the Director of Operations revealed:  - The facility staff would be trained on Safety Care to replace NCI.  - Confirmed there was no evidence staff had			MHL051-138	B. WING		7077	
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THE LIGHTHOUSE III OF CLAYTON  CLAYTON, NC 27520  I(A) D SUMMARY STATEMENT OF DEPICIENCIES (EACH DEPICIENCY MUST all SPRECEDED BY PULL RECULATION OR LSC IDENTIFYING INFORMATION)  PRETIX TAG  This Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure the Clinical Director and one of two audited staff (#1) had training in seclusion, physical restraint and isolation time-out. The finding are:  Review on 5/7/19 of Staff #1's personnel record revealed: - Hire date: 12/9/17 - Job title: 3rd Shift Residential Counselor - Previous training NCI completed 1/20/18 - 1/20/19 - There was no current training in seclusion, physical restraint and isolation time-out.  Review on 5/7/19 of the Clinical Director personnel record revealed: - Hire date: 8/4/15 - Job title: Crinical Director - Previous training NCI completed 4/24/18-4/24/19 - There was no current training in seclusion, physical restraint and isolation time-out.  Interview on 5/7/19 with the Director of Operations revealed: - The facility staff would be trained on Safety Care to replace NCI Clinical Director reported she started segments of the training He would contact the trainer to obtain status of completion for staff Confirmed there was no evidence staff had	NAME OF P	ROVIDER OR SUPPLIER					
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-Confirmed there was no evidence staff had		-He would contact the	e trainer to obtain status of				
and isolation time-out.		-Confirmed there was current training in sec	clusion, physical restraint				

STATE FORM

		In Property			FOR	RIVIAPPROVEL
	of Health Service Regu	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DAT	E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COM	IPLETED
						R
		MHL051-138	B. WING		0!	5/07/2019
				710.0005		E 452 H
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	E, ZIP CODE		
THE LIGH	THOUSE II OF CLAYTON	1	RT DRIVE N, NC 27520			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C		(×5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	IE APPROPRIATE	COMPLETE DATE
V 736	Continued From page	2 12	V 736			SWOLED
*******	27G .0303(c) Facility	and Grounds Maintenance	V 736			
	10A NCAC 27G .0303	3 LOCATION AND				
	EXTERIOR REQUIR					719
	(c) Each facility and it					
		clean, attractive and orderly				
11.		kept free from offensive				
our reports	odor.					to satisfied miners
mark of the						
	This Rule is not met					
1		and interview, the facility				
	tailed to ensure facilit	y grounds were maintained re manner. The findings are:				
	in a sale and attractiv	e marmer. The indings are.				
	Observation on 5/7/19	9 at 10:00 a.m. revealed:				
	-Two of the floor tiles	in the client's bathroom				
	were cracked.					
		floor tile, the tile would				
	come up.	Jakkina in diant'a hadroom				
	under the bed, on the	clothing in client's bedroom				
		not hanging up in the				
	closet.					
	-The bedroom with th	e sink closet door was				
	cracked					
		ains on the carpet in the				
	living room.	t in different areas of the				
		t in different areas of the hes covering damages.	4			
	-The house needed to					
		**************************************				
	Interview on 5/7/19 w					
		I the issues and would	i i			
		s. There was a maintenance				
	team on the premises	s to fix some of the				
	damages.		1			

STATE FORM

Division of Health Service Regulations of Deficiencies and Plan of Correction		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	(X2) MULTIPLE CONSTRUCTION	
		IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
		MHL051-138			R <b>05/07/2</b> 019
NAME OF PROVIDER OR SUPPLIER STREET AL			DDRESS, CITY, STATE, ZIP CODE		
THE HOUTHOUSE II OF CLAVION			RT DRIVE DN, NC 27520		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG  PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		SHOULD BE COMPLETE		
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STATE FORM

## PLAN OF CORRECTION

LH<sub>2</sub>

Annual & Follow-Up Survey completed on May 7, 2018

KMG Holdings, Inc.

The Lighthouse II of Clayton

2016 Fort Dr.

Clayton, NC 27520

MHL-051-138

DHSR - Mental Health

MAY 1 6 2019

Lic. & Cert. Section

## PLAN OF CORRECTION

Annual & Follow-Up Survey completed May 7, 2018

V113 27G .0206 Client Records

10A NCAC 27G .0206 CLIENT RECORDS

## During the Annual & Follow-Up Survey the following deficiencies were noted:

- 1. Facility failed to ensure admission information was completed for one of three clients.
- 2. Failed to ensure therapy notes were documented and filed for 4 of 4 clients.

## Solution:

Beginning immediately, the KMG Holdings, Inc. Leadership Team will begin to correct the noted deficiencies. The Clinical Director will ensure an Admission Assessment is completed for the affected consumer. The Clinical Director will also ensure all other consumers have Admission Assessments completed. The Clinical

Director will also ensure that Therapy Notes are typed, printed, and signed for all consumers. At the time of the survey the notes were not typed and available.

On a weekly basis, The Leadership Team will discuss and document during the weekly Leadership Team Mtg. the status of all consumer Admission Assessments and Therapy Notes. If it is identified that Admission Assessments and/or Therapy Notes are not completed, the Clinical Director will ensure they are completed before the end of the meeting week. The Leadership Team will continue to explore on a weekly basis solutions and ways to this process.

V 536 27E. 0107 Clients Rights – Training on Alt to Rest. Int.

10A NCAC 27E .0107 Training on Alternatives to Restrictive Interventions

## During the Annual & Follow-Up Survey the following deficiencies were noted:

1. The Facility failed to ensure the Clinical Director and one of two audited staff had current training in alternatives to restrictive interventions.

### Solution:

The KMG Holdings, Inc. Leadership Team has begun to correct the noted deficiency. At the time of the survey, the Clinical Director and the affected staff member had completed half of the Safety Care Training. Safety Care is tool the agency utilizes for Restrictive Interventions and Restraints. The second half of the training is scheduled for mid-June 2019. The Leadership Team will discuss staff trainings on a weekly basis during the Leadership Team Mtg. The Leadership Team will continue to conduct monthly Peer/File Reviews to ensure all staff trainings are up to date.

# V 537 27E .0108 Clients Rights - Training in Sec, Rest & ITO

10A NCAC 27E .0108 Training in Seclusion, Physical Restraint, and Isolation Time-Out

# During the Annual & Follow-Up Survey the following deficiencies were noted:

1. The facility failed to ensure the Clinical Director and one of two audited staff had training in seclusion, physical restraint, and isolation time-out.

#### **Solution:**

The KMG Holdings, Inc. Leadership Team has begun to correct the noted deficiency. At the time of the survey, the Clinical Director and the affected staff member had completed half of the Safety Care Training. Safety Care is tool the agency utilizes for Restrictive Interventions and Restraints. The second half of the training is scheduled for mid-June 2019. The Leadership Team will discuss staff trainings on a weekly basis during the Leadership Team Mtg. The Leadership Team will continue to conduct monthly Peer/File Reviews to ensure all staff trainings are up to date.

Respectfully submitted,

Delwin Clark, Dir. Of Operations

Date