Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL051-138	A. BUILDING: _____ B. WING _____	R 05/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LIGHTHOUSE II OF CLAYTON	2016 FORT DRIVE CLAYTON, NC 27520

(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 An annual and follow-up survey was completed on May 7, 2019. There were deficiencies cited. This facility is licensed for the following service category: 10A NCAC 27G. 1700 Residential Treatment Staff Secure for Children or Adolescents	V 000		
V 113	27G .0206 Client Records 10A NCAC 27G .0206 CLIENT RECORDS (a) A client record shall be maintained for each individual admitted to the facility, which shall contain, but need not be limited to: (1) an identification face sheet which includes: (A) name (last, first, middle, maiden); (B) client record number; (C) date of birth; (D) race, gender and marital status; (E) admission date; (F) discharge date; (2) documentation of mental illness, developmental disabilities or substance abuse diagnosis coded according to DSM IV; (3) documentation of the screening and assessment; (4) treatment/habilitation or service plan; (5) emergency information for each client which shall include the name, address and telephone number of the person to be contacted in case of sudden illness or accident and the name, address and telephone number of the client's preferred physician; (6) a signed statement from the client or legally responsible person granting permission to seek emergency care from a hospital or physician; (7) documentation of services provided; (8) documentation of progress toward outcomes; (9) if applicable:	V 113	DHSR - Mental Health MAY 16 2019 Lic. & Cert. Section	

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V 113	Continued From page 1 (A) documentation of physical disorders diagnosis according to International Classification of Diseases (ICD-9-CM); (B) medication orders; (C) orders and copies of lab tests; and (D) documentation of medication and administration errors and adverse drug reactions. (b) Each facility shall ensure that information relative to AIDS or related conditions is disclosed only in accordance with the communicable disease laws as specified in G.S. 130A-143. This Rule is not met as evidenced by: Based on record reviews and interview, the facility failed to ensure admission information was completed for one of three clients (#3) and ensure therapy notes were documented and filed for 4 of 4 clients (#1, #2, #3, #4). The findings are: A. Review on 5/7/19 of Client #3's record revealed: -There was no admission date. -Diagnoses of Conduct Disorder, Unspecified Onset, Disruptive Mood Dysregulation Disorder, Adjustment Disorder with Mixed Emotions and Attention Deficit Hyperactivity Disorder. -There was no screening and/or assessment in the client's record. Interview on 5/7/19 with the Clinical Director revealed: -Confirmed client #3 admission date and assessment was not in the record. -She reported the former program director might have the assessment on his computer.	V 113		

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V 113	Continued From page 2 -Reported client #3 was admitted in September 2018. 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 notes. -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.	V 113		

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V 536	27E .0107 Client Rights - Training on Alt to Rest. Int. 10A NCAC 27E .0107 TRAINING ON 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	V 536		

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behavior;
(3) recognizing the effect of internal and external stressors that may affect people with 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

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instructor training program.
(3) 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.
(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

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V 536	Continued From page 6 request and review this documentation any time. (k) 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. (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 the Clinical Director and one of two audited staff (#1) had current training in alternatives to restrictive interventions. The findings are: Review on 5/7/19 of Staff #1's personnel record revealed: - Hire date: 12/9/17. - Job title: 3rd Shift Residential Counselor - PreviousNCI training completed 1/20/18 - 1/20/19. - There was no current training in alternative to restrictive interventions. Review on 5/7/19 of the Clinical Director personnel record revealed: - Hire date: 8/4/15. - Job title: Clinical Director - Previous NCI training completed 4/24/18-4/24/19.	V 536		

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V 536	Continued From page 7 - There was no current training in alternative to restrictive interventions. 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 current training in alternatives to restrictive interventions.	V 536		
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 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	V 537		

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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 (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.

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V 537	Continued From page 9 (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 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;	V 537		

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V 537	Continued From page 10 (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. (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.	V 537		

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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: 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.
-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 current training in seclusion, physical restraint and isolation time-out.

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V 736	Continued From page 12	V 736		
V 736	27G .0303(c) Facility and Grounds Maintenance 10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS (c) Each facility and its grounds shall be maintained in a safe, clean, attractive and orderly manner and shall be kept free from offensive odor. This Rule is not met as evidenced by: Based on observation and interview, the facility failed to ensure facility grounds were maintained in a safe and attractive manner. The findings are: Observation on 5/7/19 at 10:00 a.m. revealed: -Two of the floor tiles in the client's bathroom were cracked. -When you walked on floor tile, the tile would come up. -There were piles of clothing in client's bedroom under the bed, on the floor and closet. -Clients clothing were not hanging up in the closet. -The bedroom with the sink closet door was cracked -There were black stains on the carpet in the living room. -The walls throughout in different areas of the house had white patches covering damages. -The house needed to be painted. Interview on 5/7/19 with the Director of Operations confirmed the issues and would address the problems. There was a maintenance team on the premises to fix some of the damages.	V 736		

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PLAN OF CORRECTION

LH2

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

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

5/15/19

Date