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
	MHL051-150	A. BUILDING: _____ B. WING _____	R 05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RHCC CAMBRIDGE PLACE CASAWORKS & PI	CAMBRIDGE PLACE - VARIOUS SUITES SMITHFIELD, NC 27577

(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 9, 2019. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .4100 Therapeutic Homes for Individuals With Substance Abuse Disorders And Their Children.	V 000	RECEIVED By DHSR - Mental Health Lic. & Cert. Section at 4:01 pm, Jun 03, 2019	
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).	V 536		

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V 536	Continued From page 1 (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; (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	V 536		

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V 536	Continued From page 2 review/request this documentation at any time. (i) Instructor Qualifications and Training Requirements: (1) Trainers shall demonstrate competence by scoring 100% on testing in a training program aimed at preventing, reducing and eliminating the need for restrictive interventions. (2) Trainers shall demonstrate competence by scoring a passing grade on testing in an instructor training program. (3) The training shall be competency-based, include measurable learning 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.	V 536		

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V 536	Continued From page 3 (j) Service providers shall maintain documentation of initial and refresher instructor training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcomes (pass/fail); (B) when and where attended; and (C) instructor's name. (2) The Division of MH/DD/SAS may request and review this documentation any time. (k) Qualifications of Coaches: (1) Coaches shall meet all preparation 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 reviews and interview, the facility failed to ensure one of four staff (#1) had current training on the use of alternatives to restrictive interventions prior to providing services. The findings are: Review on 5/9/19 of Staff #1's personnel records revealed: -Hire date of April 2005. -Staff #1 was hired as a Behavioral Health Technician. -There was no documentation that Staff #1 had	V 536		

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V 536	Continued From page 4 an updated training on the use of alternatives to restrictive interventions. Interview on 5/9/19 with the Human Resources Director revealed: -Agency only applied alternatives to restrictive interventions. -Agency used EBPI Interventions-Prevent as curriculum to meet training on alternatives to restrictive interventions. -Staff #1 had just come back from sick leave. -Staff #1 was scheduled for EBPI training at the end of May 2019. -He confirmed Staff #1 did not have an updated training on the use of alternatives to restrictive interventions.	V 536		
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 clean, safe and attractive manner. The findings are: Observation on 5/9/19 between 1:15 p.m. and 2:20 p.m. revealed: - Apartment (Apt) 101 - Walls from living area and kitchen needed to be repainted as they were dirty,	V 736		

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V 736	Continued From page 5	V 736		

scratched and stained.
- Upstairs walls had scratches on them.
- Apt 102 - The front door had stains on it.
- Air conditioning vents were rusted.
- Air conditioning intake vent was rusted.
- Apt 103 (Day care unit)- Carpet in stairs had several dark stains.
- Apt 104 -Walls from living area, kitchen and upstairs bedrooms needed to be repainted as they were dirty, scratched and stained.
-Stains were observed on the front door.
- Apt 105- Walls from living area and kitchen needed to be repainted as they were dirty, scratched and stained.
- Apt 106- Walls from living area, kitchen and upstairs bedrooms needed to be repainted as they were dirty, scratched and stained.
- Apt 108- Walls from living area, kitchen, stairs and upstairs bedrooms needed to be repainted as they were dirty, scratched and stained.
- Stains were observed on the front door.
- Apt 110 - Frame of front door was rotten on the lower right corner.
- Apt 114 - Bottom of corner wall in the kitchen was scrapped/torn off.
- Walls from living area and kitchen needed to be repainted as they were dirty, scratched and stained.
- Wood railings at entrance were stained.
- Upstairs bathrooms were missing light bulbs. Bathroom #1 had only one bulb out of four. Bathroom #2 only had one bulb out of three.
- Apt 116 - Paint on wall by entrance door was peeling off.
- Stair walls were dirty, scratched and stained.
- Upstairs bathrooms were missing light bulbs. Bathroom #1 had only one bulb out of four. Bathroom #2 had two bulbs out of three.
- Apt 118 - Some of the railings on front steps

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V 736	Continued From page 6 were rotten. - Front door was dirty and stained. - Carpet on stairs were stained. - Upstairs bathrooms were missing light bulbs. Bathroom #1 had only one bulb out of four. Bathroom #2 only had one bulb out of three. - Walls from living area and kitchen needed to be repainted as they were dirty, scratched and stained. - Apt 120 - Some of the railings on front steps were rotten. - Walls from living area and kitchen needed to be repainted as they were dirty, scratched and stained. - Wall from bedroom #2 had a section that was peeled off. - Apt 122 - Some railings on the front steps were rotten. - Blinds by the kitchen door were broken. - Blinds in bedroom #1 had broken parts. - Upstairs bathrooms were missing light bulbs. Bathroom #1 had only one bulb out of four. Bathroom #2 only had one bulb out of three. - For apartments 101-105, the outside of the building walls showed mold/mildew.	V 736		

Cambridge Place Annual Audit
Providers Identification #- MHL051-150
Date of Audit: May 9, 2019
Date: June 3, 2019

Corrective Action Plan for Cambridge

V536

Agency currently has a written policy that all employees are to be trained annual on NCI/EBPI. Senior staff member provides training on alternative to restrictive intervention for all Robeson Heath care corporation employees. Program Director has training flow sheet to identify needed training and Human resource department is a back up system for training needs for all staff. As of June 3, 2019, identified staff member has been successfully trained on EBPI.

V736 Contacted necessary parties on June 3, 2019 to make repairs stair rails, power washing, repainting apartments and cleaning of carpet stairs. Blinds and light bulbs replaced as of June 3, 2019. Will continue monthly inspection identify need repairs and ensure safety.

Cambridge Place
Program Director: Nina Taylor MSW LCAS LCSW CCS 6/3/2019

NC DEPARTMENT OF
HEALTH AND
HUMAN SERVICES

ROY COOPER • Governor
MANDY COHEN, MD, MPH • Secretary
MARK PAYNE • Director, Division of Health Service Regulation

May 14, 2019

Kim Taylor, Program Director
Robeson Health Care Corporation
109 Cambridge Place
Smithfield, NC 27577

Re: Annual & Follow-up Survey completed May 9, 2019
RHCC Cambridge Place Casaworks & Perinatal, 109 Cambridge Place, Smithfield, NC 27577
MHL # 051-150
E-mail Address: bart_grimes@RHCC1.com

Dear Ms. Taylor:

Thank you for the cooperation and courtesy extended during the annual & follow-up survey completed May 9, 2019.

As a result of the follow up survey, it was determined that all of the deficiencies are now in compliance, which is reflected on the enclosed Revisit Report. Additional deficiencies were cited during the survey.

Enclosed you will find all deficiencies cited listed on the Statement of Deficiencies Form. The purpose of the Statement of Deficiencies is to provide you with specific details of the practice that does not comply with state regulations. You must develop one Plan of Correction that addresses each deficiency listed on the State Form, and return it to our office within ten days of receipt of this letter. Below you will find details of the type of deficiencies found, the time frames for compliance plus what to include in the Plan of Correction.

Type of Deficiencies Found

- All other tags cited are standard level deficiencies.

Time Frames for Compliance

- Standard level deficiencies must be ***corrected*** within 60 days from the exit of the survey, which is July 9, 2019.

What to include in the Plan of Correction

- Indicate what measures will be put in place to ***correct*** the deficient area of practice (i.e. changes in policy and procedure, staff training, changes in staffing patterns, etc.).
- Indicate what measures will be put in place to ***prevent*** the problem from occurring again.
- Indicate ***who will monitor*** the situation to ensure it will not occur again.
- Indicate ***how often*** the monitoring will take place.
- Sign and date the bottom of the first page of the State Form.

Make a copy of the Statement of Deficiencies with the Plan of Correction to retain for your records.
Please do not include confidential information in your plan of correction and please remember never to send confidential information (protected health information) via email.

MENTAL HEALTH LICENSURE & CERTIFICATION SECTION
NC DEPARTMENT OF HEALTH AND HUMAN SERVICES • DIVISION OF HEALTH SERVICE REGULATION
LOCATION: 1800 Umstead Drive, Williams Building, Raleigh, NC 27603
MAILING ADDRESS: 2718 Mail Service Center, Raleigh, NC 27699-2718
www.ncdhhs.gov/dhsr • TEL: 919-855-3795 • FAX: 919-715-8078
AN EQUAL OPPORTUNITY / AFFIRMATIVE ACTION EMPLOYER

Send the original completed form to our office at the following address within 10 days of receipt of this letter.

Mental Health Licensure and Certification Section
NC Division of Health Service Regulation
2718 Mail Service Center
Raleigh, NC 27699-2718

A follow up visit will be conducted to verify all violations have been corrected. If we can be of further assistance, please call Bryson Brown, Team Leader at 919-855-3822.

Sincerely,

Edgar Garrido, MSW
Facility Compliance Consultant I
Mental Health Licensure & Certification Section

Cc: qmemail@cardinalinnovations.org
DHSR@Alliancebhc.org
_DHSR_Letters@sandhillscenter.org

RHCC
Your Health Care Guardian

FAX
COVER SHEET

DATE: 6/3/19 **TIME:** 3:45 **A.M./(P.M)**

FROM: Kim Taylor **TO:** DHSR

NUMBER OF PAGES (including cover sheet): 11

MESSAGE:

Corrective Action Plan

Corporate & Medical

	PHONE		FAX
Corporate	910-521-2900	HR	910-775-9161
		IT	910-775-9162
		Mgt.	910-775-9164
		Billing	910-775-9165
CCCHC	910-207-6440		910-207-6444
HCCHC	910-565-3770		910-565-3773
JTP	910-521-2816		910-521-3583
		Nursing	910-521-2878
LHC	910-739-1666		910-739-6822
		Nursing	910-739-6732
MCCHC	910-428-9020		910-428-9022
MMC	910-844-5253		910-844-3290
		Nursing	910-844-3716
SCCHC	910-506-4682		910-506-4729
SRMC	910-628-6711		910-628-5735
		Nursing	910-628-8001

Professional Counseling & Other Services

	PHONE	FAX
Cambridge Place	919-989-8114	919-938-0503
Crystal Lake	910-245-4339	910-245-4799
Grace Court	910-618-9912	910-618-0728
Men's Recovery Home	910-738-5545	910-738-5565
Our House	910-521-1464	910-521-1852
Prevention Services	910-738-2110	910-738-2988
Ryan White Program	910-738-2110	910-738-2988
The Village	252-752-5555	252-752-5455

ROBESON HEALTH CARE CORPORATION • CORPORATE HEADQUARTERS
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