STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL064-057	A. BUILDING: _____ B. WING _____	07/24/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH ROCKY MOUNT HOME	3192 GYPSY TRAIL ROCKY MOUNT, NC 27803

(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 complaint survey was completed on July 24, 2019. The complaint was substantiated Intake #NC00152148. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living Developmentally for Disabled Adults.	V 000		
V 108	27G .0202 (F-I) Personnel Requirements 10A NCAC 27G .0202 PERSONNEL REQUIREMENTS (f) Continuing education shall be documented. (g) Employee training programs shall be provided and, at a minimum, shall consist of the following: (1) general organizational orientation; (2) training on client rights and confidentiality as delineated in 10A NCAC 27C, 27D, 27E, 27F and 10A NCAC 26B; (3) training to meet the mh/dd/sa needs of the client as specified in the treatment/habilitation plan; and (4) training in infectious diseases and bloodborne pathogens. (h) Except as permitted under 10a NCAC 27G .5602(b) of this Subchapter, at least one staff member shall be available in the facility at all times when a client is present. That staff member shall be trained in basic first aid including seizure management, currently trained to provide cardiopulmonary resuscitation and trained in the Heimlich maneuver or other first aid techniques such as those provided by Red Cross, the American Heart Association or their equivalence for relieving airway obstruction. (i) The governing body shall develop and implement policies and procedures for identifying,	V 108		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL064-057	A. BUILDING: _____ B. WING _____	07/24/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH ROCKY MOUNT HOME	3192 GYPSY TRAIL ROCKY MOUNT, NC 27803

(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 108	Continued From page 1 reporting, investigating and controlling infectious and communicable diseases of personnel and clients. This Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure 3 of 3 audited staff received training to meet the needs of mh/dd (mental health/developmental disability). The findings are: Review on 7/15/19 of client #1's record revealed: - admitted to the facility 5/19/15 - diagnoses of Moderate Intellectual Developmental Disability (IDD); Sleep Apnea; Schizoaffective Disorder and Diabetes - FL2 dated 8/28/18: Benzotropine 1mg twice a day (can treat Parkinson and side effects of other drugs) & Olanzapine .5mg twice a day (can treat mental disorder) - a psychological dated 4/30/19 which includes Intermittent Explosive Disorder Review on 7/19/19 of client #3's record revealed: - admitted 3/10/08 - diagnoses of Intermittent Explosive Disorder & IDD - a psychological dated 10/10/17 defined Intermittent Explosive Disorder as follows "...people with Intermittent Explosive Disorder may attack others and their possessions, causing bodily injury and property damage...later they may feel remorse, regret or embarrassment..." During interview on 7/24/19 the Program Director reported: - client #3 explodes more than client #1	V 108		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL064-057	A. BUILDING: _____ B. WING _____	07/24/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH ROCKY MOUNT HOME	3192 GYPSY TRAIL ROCKY MOUNT, NC 27803

(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 108	Continued From page 2 - there was an isolated incident in July 2019 - client #3 became upset with a staff which was client #1's 1:1 worker...client #1 was in his bedroom...he thought client #3 was going to attack his worker...he came out of his bedroom and attacked client #3 causing injury to his left ear. The incident happened quickly... - there have been no issues between the two and they are actually friends - Intermittent Explosive training would be helpful for staff to better understand the behaviors of client #1 & client #3 During interview on 7/18/19 the Executive Director reported: - Intermittent Explosive Disorder training was provided when client #3 was admitted - she was not able to locate the documentation of the Intermittent Explosive Disorder training - staff will be retrained in this area	V 108		
V 118	27G .0209 (C) Medication Requirements 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	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL064-057	A. BUILDING: _____ B. WING _____	07/24/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH ROCKY MOUNT HOME	3192 GYPSY TRAIL ROCKY MOUNT, NC 27803

(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 118	Continued From page 3 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 administered; and (E) name or initials of person 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. This Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure medications were administered on a written physician's order for one of three clients (#3) and failed to keep MARs current for 3 of 3 clients (#1, #2 & #3). The findings are: Review on 7/15/19 of client #1's record revealed: - admitted to the facility 5/19/15 - diagnoses of Moderate Intellectual Developmental Disability (IDD); Sleep Apnea; Schizoaffective Disorder and Diabetes - FL2 dated 3/2/19: Atorvastatin 10mg everyday (can treat high cholesterol; Benzotropine 1mg twice a day (can treat Parkinson and side effects of other drugs); Chlorpromazine 50mg (can treat mental illness & behavioral disorders); Levetiracetam 750mg 1 1/2 every 12 hours (can treat seizures); Paliperidone 6mg 2 by mouth morning (can treat schizophrenia) & Fluoxetine 40mg everyday (can	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL064-057	A. BUILDING: _____ B. WING _____	07/24/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH ROCKY MOUNT HOME	3192 GYPSY TRAIL ROCKY MOUNT, NC 27803

(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 118	Continued From page 4 treat depression) Review on 7/19/19 & 7/24/19 of client #2's record revealed: - admitted to the facility on June 2007 - diagnoses of Moderate IDD; Schizophrenia; Adjustment Disorder; Hypotension; Seizure Disorder & Hyperlipidemia - a FL2 dated 6/21/19: Fludrocortisone .1mg everyday (used when the body does not produce of enough of its own steroids); Lamotrigine 200mg twice day (can treat seizures & bipolar); Mirtazapine 45mg at bedtime (can treat depression); Montelukast 10mg everyday (can treat allergies and prevent asthma attacks) Review on 7/19/19 of client #3's record revealed: - admitted 3/10/08 - diagnoses of Intermittent Explosive Disorder & IDD - a physician's consultation dated 7/5/19: "cut on left ear...Keflex twice a day for 7 days" (can treat infections) - a FL2 dated 8/2/18: Benzotropine 1mg twice a day; Divalproex 500mg bedtime (can treat seizures); Ranitidine 150mg (can treat heartburn); Olanzapine 5mg twice a day (can treat mental disorders) & Miralax everyday (can treat occasional constipation) A. The following is an example of a medication not administered based on a physician's order: Review on 7/24/19 of client #3's July 2019 MAR revealed: - Keflex was started on 7/8/19 During interview on 7/24/19 the Qualified Professional (QP) reported: - the pharmacy used by the agency was out of	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL064-057	A. BUILDING: _____ B. WING _____	07/24/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH ROCKY MOUNT HOME	3192 GYPSY TRAIL ROCKY MOUNT, NC 27803

(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 118	Continued From page 5 town - staff had to use the backup pharmacy to get the Keflex - he was not sure why the medication was not obtained until 7/8/19 B. The following is an example of how MARs were not kept current: 1. Review on 7/18/19 of client #1's May, June & July 2019 MARs revealed: - several blank spaces without staff signatures - the above medications for client #1 had not been initialed either on the May, June or July 19 MARs 2. Review on 7/18/19 of client #2's May, June & July 2019 MARs revealed: - several blank spaces without staff signatures - the above medications for client #2 had not been initialed either on the May, June or July 19 MARs 3. Review on 7/18/19 of client #3's May, June & July 2019 MARs revealed: - several blank spaces without staff signatures - the above medications for client #3 had not been initialed either on the May or July 19 MARs During interview on 7/24/19 the QP reported: - the House Manager (HM) left May 2019 - she was responsible for reviewing the MARs - now he was responsible for reviewing the MARs until another HM was hired - he reviewed MARs 1x or 2x a week - he found MARs not being initialed by staff - nothing has been put in place to address staff not initialing the MARs after administration - he planned to meet with his supervisor to address the issues	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL064-057	A. BUILDING: _____ B. WING _____	07/24/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH ROCKY MOUNT HOME	3192 GYPSY TRAIL ROCKY MOUNT, NC 27803

(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 118	Continued From page 6 Due to the failure to accurately document medication administration it could not be determined if clients received their medications as ordered by the physician	V 118		
V 121	27G .0209 (F) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (f) Medication review: (1) If the client receives psychotropic drugs, the governing body or operator shall be responsible for obtaining a review of each client's drug regimen at least every six months. The review shall be to be performed by a pharmacist or physician. The on-site manager shall assure that the client's physician is informed of the results of the review when medical intervention is indicated. (2) The findings of the drug regimen review shall be recorded in the client record along with corrective action, if applicable. This Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure 2 of 3 clients (#1 & #2) received drug regimen at least every six months. The findings are: Review on 7/15/19 of client #1's record revealed: - admitted to the facility 5/19/15 - diagnoses of Moderate Intellectual Developmental Disability (IDD); Sleep Apnea; Schizoaffective Disorder and Diabetes - FL2 dated 8/28/18: Benzotropine 1mg twice a day (can treat Parkinson and side effects of other	V 121		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL064-057	A. BUILDING: _____ B. WING _____	07/24/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH ROCKY MOUNT HOME	3192 GYPSY TRAIL ROCKY MOUNT, NC 27803

(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 121	Continued From page 7 drugs) & Olanzapine .5mg twice a day (can treat mental disorder) - no 6 month drug regimen Review on 7/19/19 & 7/24/19 of client #2's record revealed: - admitted to the facility on June 2007 - diagnoses of Moderate IDD; Schizophrenia; Adjustment Disorder; Hypotension; Seizure Disorder & Hyperlipidemia - a physician's order dated 3/9/18: Seroquel 300mg 2 by mouth twice a day (can treat Schizophrenia) - no 6 month drug regimen During interview on 7/24/19 the Qualified Professional reported: - the House Manager (HM) was responsible for ensuring drug regimens were completed - she left May 2019 - he would be responsible for the completion of drug regimens until another HM was hired	V 121		
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	V 536		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL064-057	A. BUILDING: _____ B. WING _____	07/24/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH ROCKY MOUNT HOME	3192 GYPSY TRAIL ROCKY MOUNT, NC 27803

(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 536	Continued From page 8 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 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	V 536		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL064-057	A. BUILDING: _____ B. WING _____	07/24/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH ROCKY MOUNT HOME	3192 GYPSY TRAIL ROCKY MOUNT, NC 27803

(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 536	Continued From page 9 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 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	V 536		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL064-057	A. BUILDING: _____ B. WING _____	07/24/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH ROCKY MOUNT HOME	3192 GYPSY TRAIL ROCKY MOUNT, NC 27803

(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 536	Continued From page 10 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 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.	V 536		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL064-057	A. BUILDING: _____ B. WING _____	07/24/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH ROCKY MOUNT HOME	3192 GYPSY TRAIL ROCKY MOUNT, NC 27803

(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 536	Continued From page 11 This Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure one of three audited staff (#1) had refresher training at least annually in restrictive intervention. The findings are: Review on 7/18/19 of staff #1's record revealed: - hired 2006 - last restrictive intervention training in record was 6/29/17 During interview on 7/24/19 Program Director reported: - the restrictive intervention used was "you're safe I'm safe" - human resources was not able to locate a current "you're safe I'm safe" certificate for staff #1 - she will be retrained on 8/2/19	V 536		