

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL064-095	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/26/2019
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NAME OF PROVIDER OR SUPPLIER STEVE AVENT	STREET ADDRESS, CITY, STATE, ZIP CODE 3925 SUNSET AVENUE ROCKY MOUNT, NC 27803
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(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 survey was completed on August 26, 2019. Deficiencies were cited. This facility is licensed for the following category: 10A NCAC 27G .5600F Supervised Living/Alternate Family Living.	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: (A) documentation of physical disorders	V 113		

DHSR - Mental Health
SEP 16 2019
Lic. & Cert. Section

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

Steve D. Avent AFL Provider

TITLE

9/13/19

(X6) DATE

Division of Health Service Regulation
STATE FORM

Division of Health Service Regulation

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STEVE AVENT

**3925 SUNSET AVENUE
ROCKY MOUNT, NC 27803**

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V 113	Continued From page 2 result of not utilizing his CPAP machine as ordered by his physician...during his hospitalization he was placed on a breathing device to asses with his breathing struggles..."	V 113	V113 <i>AFL provider will schedule follow up with primary care doctor. scheduled 8/28/19 to determine if mother mask can be used other than the mask member refuses to wear.</i>	
	Observation on 8/22/19 at 11:23am of client #1 revealed: - him lying on his bed with use of his oxygen machine During interview on 8/22/19 client #1 reported: - when asked if he used his CPAP machine, stated he used his oxygen machine During interview on 8/23/19 the Licensee reported: - client #1 was hospitalized January 2019 for COPD - he started using an oxygen machine to assist with his breathing - he also had a CPAP machine - it was difficult to get client #1 to use the CPAP machine - he did not like the CPAP because it covered his mouth & nose - a representative with the CPAP machine company was trying to locate a different machine for him to use - client #1's physician was aware he did not like to wear the CPAP machine - he does use the oxygen machine because it did not cover his mouth and nose - he encouraged client #1 to use the CPAP machine nightly - he does not document client #1's refusals or when he encourages client #1 to use the CPAP machine Attempted telephone calls to the Qualified Professional on 8/23/19 & 8/26/19		<i>AFL provider will document members' refusals to wear CPAP on behavior log provided by QP.</i> <i>AFL provider will link member to Cognitive behavior Therapy as recommended by primary care doctor on 8/28/19 to improve CPAP compliance.</i> <i>QP will monitor monthly and assist with linking to cognitive behavior therapy.</i>	

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V 290	27G .5602 Supervised Living - Staff 10A NCAC 27G .5602 STAFF (a) Staff-client ratios above the minimum numbers specified in Paragraphs (b), (c) and (d) of this Rule shall be determined by the facility to enable staff to respond to individualized client needs. (b) A minimum of one staff member shall be present at all times when any adult client is on the premises, except when the client's treatment or habilitation plan documents that the client is capable of remaining in the home or community without supervision. The plan shall be reviewed as needed but not less than annually to ensure the client continues to be capable of remaining in the home or community without supervision for specified periods of time. (c) Staff shall be present in a facility in the following client-staff ratios when more than one child or adolescent client is present: (1) children or adolescents with substance abuse disorders shall be served with a minimum of one staff present for every five or fewer minor clients present. However, only one staff need be present during sleeping hours if specified by the emergency back-up procedures determined by the governing body; or (2) children or adolescents with developmental disabilities shall be served with one staff present for every one to three clients present and two staff present for every four or more clients present. However, only one staff need be present during sleeping hours if specified by the emergency back-up procedures determined by the governing body. (d) In facilities which serve clients whose primary diagnosis is substance abuse dependency: (1) at least one staff member who is on duty shall be trained in alcohol and other drug	V 290	V 290 AFK provider and QP updated members unsupervised Assessment 9/5/19. Members unsupervised time Assessment will be updated annually or as needed if there is a change in status in areas of health and safety. - QP will will monitor Monthly. - QP will coordinate with member's Care Coordinator to get use of unsupervised time added to ISP/PCP.		

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V 290	<p>Continued From page 4</p> <p>withdrawal symptoms and symptoms of secondary complications to alcohol and other drug addiction; and</p> <p>(2) the services of a certified substance abuse counselor shall be available on an as-needed basis for each client.</p> <p>This Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure one of three clients (#1)'s treatment plan documented he was capable of being in the community and facility without supervision. The findings are:</p> <p>Review on 8/22/19 of client #1's record revealed:</p> <ul style="list-style-type: none"> - admitted 9/3/10 - diagnoses of Chronic Obstructive Pulmonary Disease (COPD); Schizoaffective and Mild Intellectual Developmental Disability - a treatment plan dated 2/20/19 with no documentation of unsupervised time <p>During interview on 8/22/19 client #1 reported:</p> <ul style="list-style-type: none"> - he had unsupervised time in the community - he walked next door to his neighbor's home - he didn't walk far because he would be short of breath <p>During interview on 8/23/19 the Licensee reported:</p> <ul style="list-style-type: none"> - client #1 had 2 hours of unsupervised time - one hour was unsupervised in the facility - the shortness of breath was due to the COPD - he rarely used his unsupervised time <p>A message was left for the Qualified Professional on 8/23/19 & 8/26/19</p>	V 290		

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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	V536 AFL staff will complete your Safe I'm Safe training by 9/5/19 Completed 9/4/19... AFL's Staff trainings will be monitored by personnel quarterly to ensure staff trainings remain current.	

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V 536	Continued From page 6 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	V 536		

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V 536	Continued From page 7 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	V 536			

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V 536	<p>Continued From page 8</p> <p>request and review this documentation any time.</p> <p>(k) Qualifications of Coaches:</p> <p>(1) Coaches shall meet all preparation requirements as a trainer.</p> <p>(2) Coaches shall teach at least three times the course which is being coached.</p> <p>(3) Coaches shall demonstrate competence by completion of coaching or train-the-trainer instruction.</p> <p>(l) Documentation shall be the same preparation as for trainers.</p> <p> </p> <p>This Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure one of one staff (Licensee) restrictive intervention was completed on an annual basis. The findings are:</p> <p>Record review on 8/23/19 of the Licensee's record revealed:</p> <ul style="list-style-type: none"> - You're Safe I'm Safe restrictive intervention certificate dated 9/21/17 <p>During interview on 8/23/19 the Licensee reported:</p> <ul style="list-style-type: none"> - the management office misplaced his current restrictive intervention certificate 	V 536			



NC DEPARTMENT OF
**HEALTH AND
HUMAN SERVICES**

ROY COOPER • Governor

MANDY COHEN, MD, MPH • Secretary

MARK PAYNE • Director, Division of Health Service Regulation

August 27, 2019

Steve Avent, Licensee
3925 Sunset Avenue
Rocky Mount, NC 27803

DHSR - Mental Health

SEP 16 2019

Lic. & Cert. Section

Re: Annual Survey completed August 26, 2019
Steve Avent, 3925 Sunset Avenue, Rocky Mount, NC 27803
MHL # 064-095
E-mail Address: N/A

Dear Mr. Avent:

Thank you for the cooperation and courtesy extended during the Annual survey completed August 26, 2019.

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 October 25, 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.

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

August 27, 2019

Steve Avent

- Sign and date the bottom of the first page of the State Form.

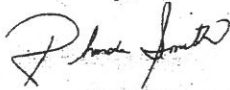
Make a copy of the Statement of Deficiencies with the Plan of Correction to retain for your records. ***Please do not include confidential information in your plan of correction and please remember never to send confidential information (protected health information) via email.***

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 Renee Ames at (919) 552-6847.

Sincerely,



Rhonda Smith
Facility Compliance Consultant I
Mental Health Licensure & Certification Section

Cc: Leza Wainwright, Director, Trillium Health Resources LME/MCO
Fonda Gonzales, Interim Quality Management Director, Trillium Health Resources LME/MCO
Pam Pridgen, Administrative Assistant

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