STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL051-114	A. BUILDING: _____ B. WING _____	09/23/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LIGHTHOUSE	956 NORTH O'NEIL STREET 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 survey was completed on September 23, 2019. Deficiencies were 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 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 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	V 118	DHSR-Mental Health OCT 0 9 2019 Lic. & Cert. Section	

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V 118	Continued From page 1 with a physician. This Rule is not met as evidenced by: Based on record review, observation and interview the facility failed to ensure medication was available and administered according to the physician for one of three audited client's. (#3). The findings are: Review on 9/23/19 with Client #3's record revealed: -Admission date of 11/2/16. -Diagnoses of Attention Deficit Hyperactivity Disorder-Combined Presentation; Borderline Intellectual Functioning by History. Review on 9/23/19 of Client #3's physician's order dated 6/21/19 and 9/10/19 revealed: -Melatonin 3 mg- Take 2 tablets in the evening. Observation on 9/23/19 at 11:00 a.m. of Client #3's medication bottles revealed: -Melatonin 5 mg. Review on 9/23/19 of Client #1's MAR for July, August and September revealed: -Medication had been marked as having been administered Melatonin 6 mg. Review on 9/23/19 of an undated and client unnamed Physician's Order revealed: -"D/c Concerta 18 mg 1 tablet in the morning. Continue all other meds as prescribed. Start Melatonin 5 mg 1 tab qhs."	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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V 118	Continued From page 2 Interview on 9/23/19 with the Clinical Director revealed: -Client #3 used to have orders for Melatonin 5 mg, but order was changed not long ago. -Facility sometimes purchased medications over the counter in order to save families some money as they were cheaper than co-pays. -Client #3 continued to receive Melatonin 5 mg as facility may had been trying to finish the bottle. -Client #3 had not had any issues with sleep lately. -Facility would purchase Melatonin 3 mg and administer it as ordered. -Facility would discontinue Melatonin 5 mg. -She acknowledged that the facility failed to ensure medication was available and administered according to the physician.	V 118		
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	V 536		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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V 536	Continued From page 3 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 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	V 536		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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V 536	Continued From page 4 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 course; (C) methods for evaluating trainee performance; and (D) documentation procedures. (6) Trainers shall have coached experience	V 536		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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V 536	Continued From page 5 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. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure one of four staff (the Qualified	V 536		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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V 536	Continued From page 6 Professional) had current training on the use of alternatives to restrictive interventions prior to providing services. The findings are: Review on 9/23/19 of the Qualified Professional's personnel records revealed: -Hire date of 3/6/17.. -The Safety-Care Behavioral Safety Trainer Recertification Training expired on 9/21/19. Interview on 9/23/19 with the Clinical Director revealed: -Agency used Safety-Care as curriculum which included two parts (de-escalation and physical restrains.) -Group home applied alternatives to restrictive interventions and physical restrains. -The Qualified Professional was the instructor for agency's staff. -The Qualified Professional had not certified any staff lately. -The Qualified Professional was scheduled for recertification in October. -She confirmed the Qualified Professional had no current training on the use of 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	V 537		

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V 537	Continued From page 7 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 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);	V 537		

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V 537	Continued From page 8 (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. (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	V 537		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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V 537	Continued from page 9 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; (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 the past 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) the trainer's name. (2) The Division of MH/DD/SAS may	V 537		

STATEMENT OF DEFICIE[illegible] AND PLAN OF CORRECT[illegible]	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SU[illegible] (EACH [illegible] REGUL[illegible]	STATEMENT OF DEFICIENCIES [illegible]NCY MUST BE PRECEDED BY FULL [illegible]OR LSC IDENTIFYING [illegible]MATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 537	Continued [illegible] page 10	V 537			

review/req[illegible] his documenta[illegible] any time.
(l) Qualifi[illegible] s of Coaches:
(1) [illegible]es shall meet all [illegible]paration requireme[illegible]s a trainer.
(2) [illegible]es shall teach at least three times, the [illegible]e which is being coached.
(3) [illegible]es shall demonstrate competen[illegible] completion of coa[illegible]ng or train-the-t[illegible] instruction.
(m) Docu[illegible]ation shall be the same preparatio[illegible]or trainers.

This Rule [illegible]t met as evidenced by:
Based on [illegible]d review and inter[illegible]view, the facility failed to [illegible] one of four staff (1[illegible] Qualified Professio[illegible]ad current training [illegible] the use of seclusion [illegible]ical restraint and iso[illegible]tion time out prior to pro[illegible]g services. The findings are:

Review o[illegible]/19 of the Qualified Professional's personnel [illegible]rds revealed:
-Hire date [illegible]6/17..
-The Safe[illegible]re Behavioral Safety Trainer Recertifi[illegible]Training expired o[illegible]/21/19.

Intervie[illegible]3/19 with the Cli[illegible]Director revealed:
-Agency [illegible]afety-Care as curr[illegible]ulum which included [illegible]rts (de-escalation and physical restrains.)
-Group ho[illegible]pplied alternatives to restrictive interventi[illegible]d physical restrain[illegible]
-The Qua[illegible]Professional was the instructor for agency's [illegible]
-The Qua[illegible]Professional had [illegible]certified any staff late[illegible]
-The Qua[illegible]Professional was [illegible]duled for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	[illegible] STATEMENT OF DEFICIENCIES [illegible]ENCY MUST BE PRECEDED BY FULL [illegible]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 537	Continue[illegible]m page 11 recertifi[illegible]n October. -She co[illegible]d the Qualified Professional had no current k[illegible]n on the use of seclusion, physical rest[illegible]olation time out.	V 537		
V 736	27G .03[illegible] Facility and Grounds Maintenance 10A NCA[illegible]G .0303 LOCATION AND EXTERI[illegible]EQUIREMENTS (c) Each [illegible]y and its grounds shall be maintain[illegible]n safe, clean, attractive and orderly manner[illegible]all be kept free from offensive odor. This Rul[illegible]t met as evidenced by: Ba[illegible]rvation and interview, the facility faile[illegible]e facility grounds were maintained in a clean[illegible]e and attractive manner. The findings a[illegible] Obs[illegible]n 9/23/19 at about 12:35 p.m. of the livin[illegible]ealed: -Couch [illegible]pped on one of the arms rest exposi[illegible]ing/stuffing. -Wa[illegible]ty/stained. Obs[illegible]n 9/23/19 at about 12:38 p.m. of the dinni[illegible]vealed: -Di[illegible]was scratched/worn off on top. -Gr[illegible]were on the ceiling. -Th[illegible]uarter side hole next to exit door. -W[illegible]ty/scratched/stained. Obs[illegible]n 9/23/19 at about 12:40 p.m. of the kitch[illegible]d: -So[illegible]abinet's doors were dirty on the	V 736		

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V 736	Continued From page 12 outside. -Door to medication closet was dirty/stained. -Refrigerator was missing part of its door handle. Observation on 9/2319 at about 12:45 p.m. of bedroom #1 (first to the left) revealed: -Dresser was missing handles on drawers. -Drawers were misaligned and hard to open. Observation on 9/23/19 at about 12:48 p.m. of hallway leading to bedrooms and staff office revealed: -There was an old printer/copier machine not being used on the floor. -Door to staff office was dirty/stained. Observation on 9/23/19 at about 12:50 p.m. of the bathroom revealed: -There was a large crack on the floor. -There was no lock on the door. -Linoleum flooring was starting to open up. Interview on 9/23/19 with the Clinical Director revealed: -She was aware facility walls were dirty/stained. -Facility painted walls constantly, but residents always got them dirty again. -Facility had never had a lock in the bathroom in attempt to avoid residents from locking themselves inside. -Agency was responsible for maintaining and replacing items as they brake down as well as painting inside the home. -She confirmed the facility failed to ensure facility grounds were maintained in a safe, clean, attractive and orderly manner.	V 736		

PLAN OF CORRECTION

LH1

Annual Survey completed on September 23, 2019

KMG Holdings, Inc.

The Lighthouse I of Clayton

956 N. O'Neil St.

Clayton, NC 27520

MHL-051-114

PLAN OF CORRECTION

Annual Survey completed September 23, 2019

V118 27G .0209 Medication Requirements

10A NCAC 27G .0209 Medication Requirements

During the Annual Survey the following deficiencies were noted:

1. Facility failed to ensure medication was available and administered according to the physician for one of three audited clients.

Solution:

Beginning immediately, the KMG Holdings, Inc. Leadership Team will begin to correct the noted deficiencies. The Clinical Director and House Manager will ensure that all consumers have a prescription order from a physician. The Clinical Director and House Manager will ensure that the proper and adequate amount of prescribed medication is present in the facility. The Clinical Director and House Manager will ensure direct care staff are administering all consumer medication in accordance with the physician order.

On a daily basis, The Clinical Director and House Manager will physically inspect all consumer MAR's and medications to ensure all medications have been administered properly from the previous day. If it is identified that medication amounts are not adequate or if medications have been administered improperly then they will take action. If medication amounts are not adequate then the House Manager will ensure a medication refill order is submitted to the pharmacy to

have the medication refilled. If it is identified that direct care staff members are administering medications improperly then the House Manager will provide additional training to the affected staff member(s). If it is determined that more training is needed they the affected staff member will be required to attend a refresher Medication Administration training class before they are allowed to administered medication to any consumer. The Leadership Team will continue to discuss this issue on a weekly basis to ensure this process is operating up to standard.

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 Survey the following deficiencies were noted:

1. The Facility failed to ensure one of four staff (the Qualified Professional) had current training on the use of alternative to restrictive interventions prior to providing services.

Solution:

The KMG Holdings, Inc. utilizes Safety Care as our restrictive intervention tool. The agency Qualified Professional is the certified Safety Care instructor for the agency. At the time of the Annual Survey the Qualified Professional's Instructor Training Certification had expired. The next certified trainer training class will take place in early November. The agency has enrolled our Qualified Professional in this training class. In the future the Leadership Team will ensure our agency Qualified Professional's Safety Care Training Certification does not expire. We will ensure the Qualified Professional is enrolled into a recertification class prior to the current certification expiring. 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 Survey the following deficiencies were noted:

1. The Facility failed to ensure one of four staff (the Qualified Professional) had current training on the use of seclusion, physical restraint, and isolation time-out prior to providing services.

Solution:

The KMG Holdings, Inc. utilizes Safety Care as our restrictive intervention tool. The agency Qualified Professional is the certified Safety Care instructor for the agency. At the time of the Annual Survey the Qualified Professional's Instructor Training Certification had expired. The next certified trainer training class will take place in early November. The agency has enrolled our Qualified Professional in this training class. In the future the Leadership Team will ensure our agency Qualified Professional's Safety Care Training Certification does not expire. We will ensure the Qualified Professional is enrolled into a recertification class prior to the current certification expiring. The Leadership Team will continue to conduct monthly Peer/File Reviews to ensure all staff trainings are up to date.

V736 27G .0303(c) Facility Grounds and Maintenance

10A NCAC 27G .0303 Location and Exterior Requirements

During the Annual Survey the following deficiencies were noted:

(Living Room)

1. Couch was ripped on one of the arm rest exposing padding/stuffing.
2. Walls are dirty/stained.

(Dining Area)

3. Dining room table was scratched/worn off on top.
4. Grease stains were on the ceiling.
5. There was a quarter sized hole next to exit door.
6. Walls were dirty/scratched/stained.

(Kitchen)

7. Some of the cabinet doors were dirty on the outside.
8. Door to med closet was dirty/stained.

(Bedroom #1)

9. Dresser was missing handles on drawers
10. Drawers were misaligned and hard to open.

(Hallway)

11. There was an old printer/copier machine not being used on the floor.
12. Door to staff office was dirty/stained.

(Bathroom)

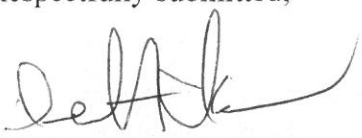
13. There was a large crack on the door.
14. There was no lock on the door.
15. Linoleum flooring was starting to open up.

The KMG Holdings, Inc. Leadership Team will conduct weekly facility maintenance checks. The team will inspect all aspects of the facility. The team will immediately make the following maintenance requests to the maintenance team and owner:

1. Replace the couch in the living room
2. Replace/repair the dining room table.
3. Replace/repair the dressers in Bedroom #1.
4. Remove the printer/copier machine from the hallway.
5. Repair the crack in the bathroom door.
6. Replace/repair the affected linoleum flooring the bathroom.
7. Repair all holes in the walls in the facility.
8. Clean and paint (where necessary) the facility walls, ceiling, and doors.
9. Clean the cabinets in the kitchen area.

The Leadership Team will be responsible for following up with the maintenance team and owner on status of ongoing repairs/replacements. The team will continue to make the necessary maintenance requests on a weekly basis.

Respectfully submitted,



Delwin Clark, Dir. Of Operations

10/9/19

Date