	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	CONSTRUCTION	COM	E SURVEY PLETED
		MHL031-039	B. WING			R 17/2019
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	ATE, ZIP CODE		
WARSAV	V GROUP HOME		TIS ROAD V, NC 28398			
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	THE APPROPRIATE	COMPLET DATE
V 000	INITIAL COMMENT	ſS	V 000			
	An annual and follo 10/17/19. Deficiend	w up survey was completed cies were cited.				
	category: 10A NCA	sed for the following service AC 27G .5600C, Supervised h Developmental Disabilities.				
V 108	27G .0202 (F-I) Per	rsonnel Requirements	V 108			
	 (g) Employee train provided and, at a r following: (1) general organiz (2) training on clier delineated in 10A N 10A NCAC 26B; 	cation shall be documented. ing programs shall be minimum, shall consist of the cational orientation; nt rights and confidentiality as ICAC 27C, 27D, 27E, 27F and				
	client as specified in plan; and	t the mh/dd/sa needs of the n the treatment/habilitation				
	.5602(b) of this Sub member shall be av times when a client member shall be tra	ens. itted under 10a NCAC 27G ochapter, at least one staff vailable in the facility at all is present. That staff ained in basic first aid				
	to provide cardiopu trained in the Heim techniques such as the American Heart equivalence for reli	anagement, currently trained Imonary resuscitation and lich maneuver or other first aid those provided by Red Cross Association or their eving airway obstruction. body shall develop and				
inion of Li	implement policies reporting, investiga	and procedures for identifying, ting and controlling infectious diseases of personnel and				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Division	of Health Service Re	egulation			FORM	APPROVED
STATEMEN	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY PLETED
		BERTH TO THOMBEN.	A. BUILDING	3:		
		MHL031-039	B. WING			R 17/2019
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
WARSAV	V GROUP HOME		TIS ROAD			
MARCA	1		N, NC 28398			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
V 108	Continued From pa	age 1	V 108			
	clients.					
		et as evidenced by: views and interviews 1 of 3				
	audited staff (Mana	ager #1) failed to have current				
	First Aid and Cardio (CPR) training. Th	opulmonary Resuscitation e findings are:				
		-				
	record revealed:	9 of Manager #1's personnel				
	- Title of Manager,					
		ssociation Basic Life Support /17, expired 5/2019.				
	- No documentation training.	n of current First Aid and CPR				
	Manager #1 was no	ot available for interview.				
		n 10/15/19 and 10/17/19 the				
		nal/Executive Director stated e documentation of Manager				
		id and CPR training; she				
		entation was in the personnel at of a medical emergency,				
	staff would call 911	. She understood the				
		st Aid and CPR training to be ould schedule Manager #1 for				
	a class within the n					
V 118	27G .0209 (C) Med	lication Requirements	V 118			
	10A NCAC 27G .02	209 MEDICATION				
	REQUIREMENTS (c) Medication adm	inistration.				
		non-prescription drugs shall				
vivision of H	ealth Service Regulation		I			
TATE FOR	M		6899	BIHT11	If continua	tion sheet 2 of 1

	IT OF DEFICIENCIES OF CORRECTION	egulation (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED
	0. 00		A. BUILDING:			
		MHL031-039	B. WING			R 17/2019
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
VARSAV	V GROUP HOME		TIS ROAD N, NC 28398			
(X4) ID	SUMMARY STA			PROVIDER'S PLAN OF	CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	COMPLET DATE
V 118	Continued From pa	ige 2	V 118			
	order of a person a drugs. (2) Medications sha clients only when a client's physician. (3) Medications, ind administered only b unlicensed persons pharmacist or other privileged to prepar (4) A Medication Ad all drugs administe current. Medication recorded immediate MAR is to include ti (A) client's name; (B) name, strength (C) instructions for (D) date and time ti (E) name or initials drug. (5) Client requests checks shall be reco	ed to a client on the written uthorized by law to prescribe all be self-administered by uthorized in writing by the cluding injections, shall be by licensed persons, or by a trained by a registered nurse, r legally qualified person and re and administer medications. Iministration Record (MAR) of red to each client must be kep s administered shall be ely after administration. The he following: , and quantity of the drug; administering the drug; he drug is administered; and of person administering the for medication changes or corded and kept with the MAR appointment or consultation				
	Based on record re facility failed to ens were recorded on e	et as evidenced by: eviews and interviews the ure medications administered each client's MAR immediately affecting 1 of 3 audited clients are:				
	Review on 10/15/19 revealed:	9 of client #3's record				

STATE FORM

STATEMEN	of Health Service Re TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
			A. BUILDING:			
		MHL031-039	B. WING			R 17/2019
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
NARSAV	V GROUP HOME		TIS ROAD V, NC 28398			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF	CORRECTION	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLET DATE
V 118	Continued From pa	age 3	V 118			
	Intellectual/Develop Diabetes. - Physician's orders (can treat high bloo (mg) 1 tablet daily, diabetes) 5 mg 1 ta nasal spray (can tre sprays to each nos heartburn and gast 20 mg 2 capsules e treat allergy sympto morning, citalopran 2 tablets daily, ferro supplement) 325 m meals with vitamin type 2 diabetes) 50 polyethylene glycol grams in 8 ounces Monday, Wednesd to check fasting blo signed artificial tear eye three times dai Review on 10/15/19	ed Unspecified Mood Disorder, omental Disability, mild, and a signed 7/31/19 for lisinopril od pressure) 2.5 milligrams glipizide (can treat type 2 ablet daily, Flonase 0.05% eat allergy symptoms), 2 tril daily, omeprazole (can treat roesophageal reflux disease) every morning, cetirizine (can oms) 10 mg 1 tablet every n (can treat depression) 20 mg ous sulfate (dietary ng 1 tablet twice daily between C juice, metformin (can treat 0 mg 1 tablet twice daily, (can treat constipation) mix 17 of beverage and drink every ay, and Friday; signed 8/23/19 bod sugar every morning; rs 1.4% "as directed to right ly."	t			
	 Transcriptions for physician. No documentation medications at 8:00 No documentation 	medications as ordered by the n of administration of) am on 9/30/19. n of administration of lisinopril	2			
	at 8:00 am 8/19/19 or 8/29/19; artificial	sulfate on 8/2/19, metformin or 8:00 pm 8/24/19, 8/25/19, tears at 2:00 pm 8/1/19, 8:00 19, 2:00 pm 8/9/19, 2:00 pm n 8/26/19.				
		10/15/19 client #3 stated she ns daily with staff assistance				

STATEME	of Health Service Re NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
			A. BUILDING:			
		MHL031-039	B. WING			R 17/2019
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
WARSA	W GROUP HOME		FIS ROAD /, NC 28398			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
V 118	Continued From pa	ge 4	V 118			
	and she had never	missed any doses.				
	Professional/Execu not document admi medications immed medications. She v were given as order Due to the failure to medication adminis	10/15/19 the Qualified tive Director stated staff did nistration of client #3's liately after giving the vas confident the medications red. accurately document tration it could not be s received their medications				
V 536	as ordered by the p 27E .0107 Client Ri Int.	hysician. ghts - Training on Alt to Rest.	V 536			
	practices that emph to restrictive interver (b) Prior to providir disabilities, staff inc employees, student demonstrate compe completing training other strategies for which the likelihood or injury to a persor property damage is (c) Provider agence based on state com compliance and der gathered. (d) The training sha include measurable	D RESTRICTIVE mplement policies and nasize the use of alternatives intions. In g services to people with luding service providers, is or volunteers, shall etence by successfully in communication skills and creating an environment in of imminent danger of abuse in with disabilities or others or				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (A1) PROVIDERSUPPLERCLA IDENTIFICATION NUMBER: (A2) MULTIPLE CONSTRUCTION A BUILDING: (A3) DATE SUM COMPLETE A BUILDING: (A3) DET SUM COMPLETE A BUILDING: (A3) DET SUM COMPLETE A BUILDING: (A3) DET SUM COMPLETE A BUILDING: (A3) DET SUM COMPLETE A BUILDING: (A4) STATE SUM COMPLETE A BU	Division	of Health Service Re	aulation			FORM A	PPROVED
MHL 031-039 E. WING 10/17/20 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 716 CURTIS ROAD WARSAW GROUP HOME 716 CURTIS ROAD WARSAW, KC 23398 000000000000000000000000000000000000	STATEMEN	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA				
WARSAW GROUP HOME 716 CURTIS ROAD WARSAW, NC 28398 OW ID PRETX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PRETX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE (CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) OC V 536 Continued From page 5 V 536 V 536 behavior) on those objectives and measurable methods to determine passing or failing the course. V 536 V 536 (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. F (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; (6) 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			MHL031-039	B. WING			
WARSAW GROUP HOME WARSAW, NC 28398 (%)ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE RECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S FLAN OF CORRECTION (EACH CORRECTWO ACTION SINOLID BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COI V 536 Continued From page 5 V 536 Cost behavior) on those objectives and measurable methods to determine passing or failing the course. V 536 EPROVIDER'S FLAN OF CORRECTION PERCINCY) DEFICIENCY) (6) 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 the effect of internal and external stressors that may affect people with disabilities; (6) strategies for building positive relationships with persons with disabilities; (6) (g) Strategies for building positive relationships with persons and making decisions about their life; (7) skills in assessing individual risk for escalating behavior; and (g) positive behavioral supports (providing means for people with disabilities to choose (g)	NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
PRÉFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PRÉFIX TAG CEACH ODRRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 0 V 536 Continued From page 5 V 536 V 536 behavior) on those objectives and measurable methods to determine passing or failing the course. V 536 V 536 (e) Formal refresher training must be completed by each service provider periodically (minimum annually). V 536 V 536 (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 (0) of this Rule. Paragraph (0) of this Rule. (g) Staff shall demonstrate competence in the following core areas: (1) knowledge and understanding of the people being served; (2) recognizing the effect of internal and external stressors that may affect people with disabilities; Strategies for building positive relationships with persons 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; and Continued for defusing and de-escalating potentially dangerous behavior; and (9) positive behavioral supports (providing means for people with disabilities to choose	WARSAV	V GROUP HOME					
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 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; (5) recognizing the university of and an assisting in the person's involvement in making decisions about their life; (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 behavior; (9) positive behavioral supports (providing means for people with disabilities; 	PRÉFIX				CROSS-REFERENCED TO THE APPRO		COMPLETE DATE
 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; (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; (9) positive behavioral supports (providing means for people with disabilities; 	V 536	Continued From pa	ge 5	V 536			
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.		methods to determine course. (e) Formal refreshe by each service pro- annually). (f) Content of the tra- provider wishes to each the Division of MH/I Paragraph (g) of thi (g) Staff shall demo- following core areas (1) knowledg people being server (2) recognizine behavior; (3) recognizine external stressors to disabilities; (4) strategiess relationships with p (5) recognizine organizational factor disabilities; (6) recognizine organizational factor disabilities; (6) recognizine organizational factor disabilities; (6) recognizine assisting in the person decisions about the (7) skills in ass escalating behavior (8) communic and de-escalating person and (9) positive be means for people we activities which dire behaviors which are (h) Service provide documentation of ine	ne passing or failing the er training must be completed wider periodically (minimum raining that the service employ must be approved by DD/SAS pursuant to s Rule. onstrate competence in the s: e and understanding of the d; ng and interpreting human ng the effect of internal and hat may affect people with for building positive ersons with disabilities; ng cultural, environmental and rs that may affect people with ng the importance of and son's involvement in making ir life; ssessing individual risk for ; cation strategies for defusing potentially dangerous behavior; ehavioral supports (providing <i>i</i> th disabilities to choose ctly oppose or replace e unsafe). rs shall maintain itial and refresher training for				

Division	of Health Service Re				FORM	APPROVED
STATEME	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		PLETED
		MHL031-039	B. WING			२ ।7/2019
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
WARSA	W GROUP HOME	716 CUR1	IS ROAD			
MANOA		WARSAW	, NC 28398			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
V 536	Continued From pa	ge 6	V 536			
	 (Å) who particle outcomes (pass/faille) when and (C) instructor (B) when and (C) instructor (2) The Division review/request this (i) Instructor Qualiffer Requirements: (1) Trainers is by scoring 100% or aimed at preventing need for restrictive (2) Trainers is by scoring a passing instructor training performance; and (D) document (6) Trainers is teaching a training performance; and elimination of the service performance; and the service pe	Where they attended; and 's name; ion of MH/DD/SAS may documentation at any time. ications and Training shall demonstrate competence in testing in a training program g, reducing and eliminating the interventions. shall demonstrate competence g grade on testing in an rogram. ng shall be , include measurable learning able testing (written and by avior) on those objectives and ds to determine passing or ent of the instructor training the ins to employ shall be vision of MH/DD/SAS pursuant (5) of this Rule. le instructor training programs e not limited to presentation of: ding the adult learner; for teaching content of the for evaluating trainee shall have coached experience program aimed at preventing, lating the need for restrictive st one time, with positive				

STATEMEN	of Health Service Re NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	СОМ	E SURVEY PLETED
		MHL031-039	B. WING			n 17/2019
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
WARSAV	W GROUP HOME		TIS ROAD V, NC 28398			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
V 536	 (7) Trainers s aimed at preventing need for restrictive annually. (8) Trainers s instructor training at (j) Service provide documentation of in training for at least (1) Docu (A) who partice outcomes (pass/fail (B) when and (C) instructor (2) The Divis request and review (k) Qualifications of (1) Coaches requirements as a (2) Coaches the course which is (3) Coaches competence by cor train-the-trainer ins 	shall teach a training program g, reducing and eliminating the interventions at least once shall complete a refresher at least every two years. rs shall maintain nitial and refresher instructor three years. mentation shall include: cipated in the training and the I); d where attended; and r's name. tion of MH/DD/SAS may this documentation any time. of Coaches: shall meet all preparation trainer. shall teach at least three times being coached. shall demonstrate mpletion of coaching or				
	Based on record re facility failed to ens (Manager #1, Mana Professional/Execu					

Division of Health Service Regulation STATE FORM

Division	of Health Service Re	egulation			FORM	APPROVED
STATEMEN	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:			E SURVEY PLETED
		MHL031-039	B. WING			R 17/2019
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
WARSAN	W GROUP HOME	716 CUR	TIS ROAD			
		WARSAV	V, NC 28398			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
V 536	Continued From pa	ige 8	V 536			
	record revealed: - Title of Manager, - No documented tr restrictive intervent	raining in alternatives to ions.				
	training in alternativ was done annually.	10/15/19 Manager #1 stated ves to restrictive interventions Restrictive interventions e facility. Staff would call 911				
	revealed: - Title of Manager, I - North Carolina Int Core+/Modified Phy completed 4/16/18.	erventions (NCI), ysical Techniques, parts A & B, n of updated training in				
	Manager #2 was no	ot available for interview.				
	record revealed: - Title of Executive - NCI Core+/Modifie A & B, completed 2	tive Director's personnel Director, hire date 10/15/12. ed Physical Techniques, parts /14/18. n of updated training in				
ivision of L	Qualified Professio - She was the Resident and the Qualified P - None of the staff halternatives to restrict	n 10/15/19 and 10/17/19 the nal/Executive Director stated: dential Services Coordinator rofessional for the facility nad current training in rictive interventions. I a "hands off" policy and				

Division of Health Service Regulation STATE FORM

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STATEMEN	of Health Service Re	(X1) PROVIDER/SUPPLIER/CLIA		CONSTRUCTION	(X3) DATE	E SURVEY PLETED
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:			
		MHL031-039	B. WING			R 17/2019
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
VARSAV	V GROUP HOME		RTIS ROAD N, NC 28398			
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	THE APPROPRIATE	COMPLET DATE
V 536	Continued From pa	ige 9	V 536			
	 She could not idea train staff in alterna interventions. She would contact 	ions were not used. ntify a qualified provider to tives to restrictive t an instructor and schedule as soon as possible.				