

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL028-019	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/22/2019
--	---	---	---

NAME OF PROVIDER OR SUPPLIER CHANGING TIDES	STREET ADDRESS, CITY, STATE, ZIP CODE 3512 NORTH VIRGINIA DARE TRAIL KITTY HAWK, NC 27949
---	---

(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	<p>INITIAL COMMENTS</p> <p>An annual and complaint survey was completed on November 22, 2019. The complaint was unsubstantiated (intake #NC00157278). Deficiencies were cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .3700 Day Treatment Facilities for Individuals with Substance Abuse Disorders.</p>	V 000		
V 118	<p>27G .0209 (C) Medication Requirements</p> <p>10A NCAC 27G .0209 MEDICATION REQUIREMENTS</p> <p>(c) Medication administration:</p> <p>(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.</p> <p>(2) Medications shall be self-administered by clients only when authorized in writing by the client's physician.</p> <p>(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.</p> <p>(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:</p> <p>(A) client's name;</p> <p>(B) name, strength, and quantity of the drug;</p> <p>(C) instructions for administering the drug;</p> <p>(D) date and time the drug is administered; and</p> <p>(E) name or initials of person administering the drug.</p> <p>(5) Client requests for medication changes or</p>	V 118		

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL028-019	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/22/2019
--	---	---	---

NAME OF PROVIDER OR SUPPLIER CHANGING TIDES	STREET ADDRESS, CITY, STATE, ZIP CODE 3512 NORTH VIRGINIA DARE TRAIL KITTY HAWK, NC 27949
---	---

(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	<p>Continued From page 1</p> <p>checks shall be recorded and kept with the MAR file followed up by appointment or consultation with a physician.</p> <p>This Rule is not met as evidenced by: Based on record reviews, observations, and interviews the facility failed to administer medications on the written order of a physician affecting 2 of 3 audited clients (#1 and #14). The findings are:</p> <p>Review on 11/18/19 of client #1's record revealed: - 41 year old male admitted 11/6/19. - Diagnoses included Polysubstance Use Disorder, Generalized Anxiety, Schizoaffective Disorder, bipolar type, Traumatic Brain Injury, Alcohol Use Disorder, severe, Stimulant Use Disorder, severe, and Opioid Use Disorder, severe. - Signed Physician order for client #1 to self-administer medications. - No medication orders signed by a Physician or other practitioner licensed to prescribe medications.</p> <p>Review on 11/18/19 of client #1's MAR for November 2019 revealed transcription for alprazolam (can treat anxiety disorder) 1 milligram (mg), take 2 tablets three times daily, with client #1 and staff initials to indicate administration of the medication three times daily.</p> <p>Observation on 11/18/19 at approximately 4:30 pm of client #1's medication revealed alprazolam 1 mg, take 2 tablets up to three times daily.</p>	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL028-019	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/22/2019
--	---	---	---

NAME OF PROVIDER OR SUPPLIER CHANGING TIDES	STREET ADDRESS, CITY, STATE, ZIP CODE 3512 NORTH VIRGINIA DARE TRAIL KITTY HAWK, NC 27949
---	---

(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	<p>Continued From page 2</p> <p>During interview on 11/18/19 client #1 stated he took his medication everyday as ordered. His medication was kept locked "in the closet." When it was time to take his medicine, staff unlocked the closet and removed his medication box. He would take his medicine himself and he and staff would initial his MAR.</p> <p>Review on 11/18/19 of client #14's record revealed:</p> <ul style="list-style-type: none"> - 35 year old male admitted 9/9/19. - Diagnoses included Alcohol Use Disorder, severe, Opioid Use Disorder, severe, and Stimulant Use Disorder, severe. - Signed Physician order for client #14 to self-administer medications. - No medication orders signed by a Physician or other practitioner licensed to prescribe medications.] - No signed Physician's orders to discontinue any medications. - "Medical Note" signed by Therapist #2 " and dated 9/10/19 included " . . . Session Focus or Topic: Medication evaluation/initial assessment Individual Note: [the Physician] met with client to assess recent relapse, motivation, and medication. Client was cleared to be in treatment. No medication changes." <p>Review on 11/18/19 of client #1's MARs for September - November 2019 revealed:</p> <ul style="list-style-type: none"> - MARs beginning October 7 thru November 18 included transcriptions for Suboxone (can treat addiction to narcotic pain relievers) 8-2 mg strips, dissolve 1 strip once daily and Latuda (anti-psychotic, can treat schizophrenia) 20 mg 1 tablet daily, and Doxepin (can treat depression, anxiety, and sleep disorders) 150 mg 1 capsule at bedtime. - MAR dated 11/11/19 - 11/17/19 included a 	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL028-019	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/22/2019
--	---	---	---

NAME OF PROVIDER OR SUPPLIER CHANGING TIDES	STREET ADDRESS, CITY, STATE, ZIP CODE 3512 NORTH VIRGINIA DARE TRAIL KITTY HAWK, NC 27949
---	---

(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	<p>Continued From page 3</p> <p>handwritten notation "11/16/19 took last Clonidine in AM [morning] 0.1 mg . . ."</p> <ul style="list-style-type: none"> - MARs beginning September 9 thru October 6 included transcriptions for Suboxone, Clonidine (can treat hypertension) 0.1 mg, take 1-2 tablets four times a day as needed (prn); transcription for evening dose of Clonidine included "take 1-2 tablets 4x [four times] day" and did not include "prn." - MARs beginning September 9 thru September 22 included transcription for chlordiazepoxide (can treat anxiety, alcohol withdrawal symptoms, and tremor) 25mg take 1-2 tablets four times daily. - All MARs included client #14 and staff initials to indicate administration of the listed medications. - "Controlled Substance Count Sheet" for chlordiazepoxide 25 mg, 9/9/19 - 10/9/15/19 signed by client #14 and staff included "Directions for Self-Administration . . . Take 1-2 capsules 4x [four times] day then as directed by doctor" and client #14 and staff initials. <p>Observation on 11/18/19 at approximately 4:35 pm of client #14's medications revealed:</p> <ul style="list-style-type: none"> - Latuda 20 mg, 1 tablet daily. - Doxepin 150 mg 1 capsule at bedtime. - Suboxone 8-2 mg strips, dissolve one strip sublingually every morning. - No Clonidine 0.1 mg; no chlordiazepoxide 25 mg. <p>During interview on 11/18/19 client #14 stated he self-administered his medications. Staff kept the medications "locked up." Staff gave clients their medications as ordered. He saw the physician monthly, but if he needed to see the doctor more frequently, he could.</p> <p>During interview on 11/18/19 the</p>	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL028-019	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/22/2019
--	---	---	---

NAME OF PROVIDER OR SUPPLIER CHANGING TIDES	STREET ADDRESS, CITY, STATE, ZIP CODE 3512 NORTH VIRGINIA DARE TRAIL KITTY HAWK, NC 27949
---	---

(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 Administrator/Supervisor stated clients saw a local physician for admission and he wrote prescriptions. The pharmacy required them to submit the prescriptions when they were filled. She did not maintain a copy of the prescriptions for the clients' records.	V 118		
V 133	G.S. 122C-80 Criminal History Record Check G.S. §122C-80 CRIMINAL HISTORY RECORD CHECK REQUIRED FOR CERTAIN APPLICANTS FOR EMPLOYMENT. (a) Definition. - As used in this section, the term "provider" applies to an area authority/county program and any provider of mental health, developmental disability, and substance abuse services that is licensable under Article 2 of this Chapter. (b) Requirement. - An offer of employment by a provider licensed under this Chapter to an applicant to fill a position that does not require the applicant to have an occupational license is conditioned on consent to a State and national criminal history record check of the applicant. If the applicant has been a resident of this State for less than five years, then the offer of employment is conditioned on consent to a State and national criminal history record check of the applicant. The national criminal history record check shall include a check of the applicant's fingerprints. If the applicant has been a resident of this State for five years or more, then the offer is conditioned on consent to a State criminal history record check of the applicant. A provider shall not employ an applicant who refuses to consent to a criminal history record check required by this section. Except as otherwise provided in this subsection, within five business days of making the conditional offer of employment, a provider	V 133		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL028-019	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/22/2019
--	---	---	---

NAME OF PROVIDER OR SUPPLIER CHANGING TIDES	STREET ADDRESS, CITY, STATE, ZIP CODE 3512 NORTH VIRGINIA DARE TRAIL KITTY HAWK, NC 27949
---	---

(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 133	Continued From page 5 shall submit a request to the Department of Justice under G.S. 114-19.10 to conduct a criminal history record check required by this section or shall submit a request to a private entity to conduct a State criminal history record check required by this section. Notwithstanding G.S. 114-19.10, the Department of Justice shall return the results of national criminal history record checks for employment positions not covered by Public Law 105-277 to the Department of Health and Human Services, Criminal Records Check Unit. Within five business days of receipt of the national criminal history of the person, the Department of Health and Human Services, Criminal Records Check Unit, shall notify the provider as to whether the information received may affect the employability of the applicant. In no case shall the results of the national criminal history record check be shared with the provider. Providers shall make available upon request verification that a criminal history check has been completed on any staff covered by this section. A county that has adopted an appropriate local ordinance and has access to the Division of Criminal Information data bank may conduct on behalf of a provider a State criminal history record check required by this section without the provider having to submit a request to the Department of Justice. In such a case, the county shall commence with the State criminal history record check required by this section within five business days of the conditional offer of employment by the provider. All criminal history information received by the provider is confidential and may not be disclosed, except to the applicant as provided in subsection (c) of this section. For purposes of this subsection, the term "private entity" means a business regularly engaged in conducting	V 133		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL028-019	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/22/2019
--	---	---	---

NAME OF PROVIDER OR SUPPLIER CHANGING TIDES	STREET ADDRESS, CITY, STATE, ZIP CODE 3512 NORTH VIRGINIA DARE TRAIL KITTY HAWK, NC 27949
---	---

(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 133	<p>Continued From page 6</p> <p>criminal history record checks utilizing public records obtained from a State agency.</p> <p>(c) Action. - If an applicant's criminal history record check reveals one or more convictions of a relevant offense, the provider shall consider all of the following factors in determining whether to hire the applicant:</p> <ol style="list-style-type: none"> (1) The level and seriousness of the crime. (2) The date of the crime. (3) The age of the person at the time of the conviction. (4) The circumstances surrounding the commission of the crime, if known. (5) The nexus between the criminal conduct of the person and the job duties of the position to be filled. (6) The prison, jail, probation, parole, rehabilitation, and employment records of the person since the date the crime was committed. (7) The subsequent commission by the person of a relevant offense. <p>The fact of conviction of a relevant offense alone shall not be a bar to employment; however, the listed factors shall be considered by the provider. If the provider disqualifies an applicant after consideration of the relevant factors, then the provider may disclose information contained in the criminal history record check that is relevant to the disqualification, but may not provide a copy of the criminal history record check to the applicant.</p> <p>(d) Limited Immunity. - A provider and an officer or employee of a provider that, in good faith, complies with this section shall be immune from civil liability for:</p> <ol style="list-style-type: none"> (1) The failure of the provider to employ an individual on the basis of information provided in the criminal history record check of the individual. (2) Failure to check an employee's history of 	V 133		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL028-019	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/22/2019
--	---	---	---

NAME OF PROVIDER OR SUPPLIER CHANGING TIDES	STREET ADDRESS, CITY, STATE, ZIP CODE 3512 NORTH VIRGINIA DARE TRAIL KITTY HAWK, NC 27949
---	---

(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 133	Continued From page 7 criminal offenses if the employee's criminal history record check is requested and received in compliance with this section. (e) Relevant Offense. - As used in this section, "relevant offense" means a county, state, or federal criminal history of conviction or pending indictment of a crime, whether a misdemeanor or felony, that bears upon an individual's fitness to have responsibility for the safety and well-being of persons needing mental health, developmental disabilities, or substance abuse services. These crimes include the criminal offenses set forth in any of the following Articles of Chapter 14 of the General Statutes: Article 5, Counterfeiting and Issuing Monetary Substitutes; Article 5A, Endangering Executive and Legislative Officers; Article 6, Homicide; Article 7A, Rape and Other Sex Offenses; Article 8, Assaults; Article 10, Kidnapping and Abduction; Article 13, Malicious Injury or Damage by Use of Explosive or Incendiary Device or Material; Article 14, Burglary and Other Housebreakings; Article 15, Arson and Other Burnings; Article 16, Larceny; Article 17, Robbery; Article 18, Embezzlement; Article 19, False Pretenses and Cheats; Article 19A, Obtaining Property or Services by False or Fraudulent Use of Credit Device or Other Means; Article 19B, Financial Transaction Card Crime Act; Article 20, Frauds; Article 21, Forgery; Article 26, Offenses Against Public Morality and Decency; Article 26A, Adult Establishments; Article 27, Prostitution; Article 28, Perjury; Article 29, Bribery; Article 31, Misconduct in Public Office; Article 35, Offenses Against the Public Peace; Article 36A, Riots and Civil Disorders; Article 39, Protection of Minors; Article 40, Protection of the Family; Article 59, Public Intoxication; and Article 60, Computer-Related Crime. These crimes also include possession or	V 133		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL028-019	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/22/2019
--	---	---	---

NAME OF PROVIDER OR SUPPLIER CHANGING TIDES	STREET ADDRESS, CITY, STATE, ZIP CODE 3512 NORTH VIRGINIA DARE TRAIL KITTY HAWK, NC 27949
---	---

(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 133	<p>Continued From page 8</p> <p>sale of drugs in violation of the North Carolina Controlled Substances Act, Article 5 of Chapter 90 of the General Statutes, and alcohol-related offenses such as sale to underage persons in violation of G.S. 18B-302 or driving while impaired in violation of G.S. 20-138.1 through G.S. 20-138.5.</p> <p>(f) Penalty for Furnishing False Information. - Any applicant for employment who willfully furnishes, supplies, or otherwise gives false information on an employment application that is the basis for a criminal history record check under this section shall be guilty of a Class A1 misdemeanor.</p> <p>(g) Conditional Employment. - A provider may employ an applicant conditionally prior to obtaining the results of a criminal history record check regarding the applicant if both of the following requirements are met:</p> <p>(1) The provider shall not employ an applicant prior to obtaining the applicant's consent for criminal history record check as required in subsection (b) of this section or the completed fingerprint cards as required in G.S. 114-19.10.</p> <p>(2) The provider shall submit the request for a criminal history record check not later than five business days after the individual begins conditional employment. (2000-154, s. 4; 2001-155, s. 1; 2004-124, ss. 10.19D(c), (h); 2005-4, ss. 1, 2, 3, 4, 5(a); 2007-444, s. 3.)</p> <p>This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to request state and federal criminal background checks within five business days of employment for 1 of 4 audited staff (Therapist</p>	V 133		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL028-019	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/22/2019
--	---	---	---

NAME OF PROVIDER OR SUPPLIER CHANGING TIDES	STREET ADDRESS, CITY, STATE, ZIP CODE 3512 NORTH VIRGINIA DARE TRAIL KITTY HAWK, NC 27949
---	---

(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 133	<p>Continued From page 9</p> <p>#1). The findings are:</p> <p>Review on 11/18/19 of Therapist #1's personnel record revealed:</p> <ul style="list-style-type: none"> - Hire date of 8/16/19, title Substance Abuse Counselor. - Employment in the state of Virginia prior to hire date. - A copy of a Virginia driver's license. - No documentation of professional licensure. - Consent for criminal background check signed 8/6/19. - No documentation of completion of a national criminal background check with fingerprints prior to employment. <p>During interview on 11/18/19 Therapist #1 stated she moved to North Carolina when she was hired by the Licensee. She was not a licensed therapist. She did not submit fingerprints for a criminal background check prior to employment.</p> <p>During interview on 11/18/19 the Administrator/Supervisor stated she thought a criminal background check had been completed for Therapist #1.</p>	V 133		
V 536	<p>27E .0107 Client Rights - Training on Alt to Rest. Int.</p> <p>10A NCAC 27E .0107 TRAINING ON ALTERNATIVES TO RESTRICTIVE INTERVENTIONS</p> <p>(a) Facilities shall implement policies and practices that emphasize the use of alternatives to restrictive interventions.</p> <p>(b) Prior to providing services to people with disabilities, staff including service providers, employees, students or volunteers, shall</p>	V 536		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL028-019	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/22/2019
--	---	---	---

NAME OF PROVIDER OR SUPPLIER CHANGING TIDES	STREET ADDRESS, CITY, STATE, ZIP CODE 3512 NORTH VIRGINIA DARE TRAIL KITTY HAWK, NC 27949
---	---

(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	<p>Continued From page 10</p> <p>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.</p> <p>(c) Provider agencies shall establish training based on state competencies, monitor for internal compliance and demonstrate they acted on data gathered.</p> <p>(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.</p> <p>(e) Formal refresher training must be completed by each service provider periodically (minimum annually).</p> <p>(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.</p> <p>(g) Staff shall demonstrate competence in the following core areas:</p> <ol style="list-style-type: none"> (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 	V 536		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL028-019	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/22/2019
--	---	---	---

NAME OF PROVIDER OR SUPPLIER CHANGING TIDES	STREET ADDRESS, CITY, STATE, ZIP CODE 3512 NORTH VIRGINIA DARE TRAIL KITTY HAWK, NC 27949
---	---

(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	<p>Continued From page 11</p> <p>decisions about their life;</p> <p>(7) skills in assessing individual risk for escalating behavior;</p> <p>(8) communication strategies for defusing and de-escalating potentially dangerous behavior; and</p> <p>(9) positive behavioral supports (providing means for people with disabilities to choose activities which directly oppose or replace behaviors which are unsafe).</p> <p>(h) Service providers shall maintain documentation of initial and refresher training for at least three years.</p> <p>(1) Documentation shall include:</p> <p>(A) who participated in the training and the outcomes (pass/fail);</p> <p>(B) when and where they attended; and</p> <p>(C) instructor's name;</p> <p>(2) The Division of MH/DD/SAS may review/request this documentation at any time.</p> <p>(i) Instructor Qualifications and Training Requirements:</p> <p>(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.</p> <p>(2) Trainers shall demonstrate competence by scoring a passing grade on testing in an instructor training program.</p> <p>(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.</p> <p>(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.</p>	V 536		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL028-019	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/22/2019
--	---	---	---

NAME OF PROVIDER OR SUPPLIER CHANGING TIDES	STREET ADDRESS, CITY, STATE, ZIP CODE 3512 NORTH VIRGINIA DARE TRAIL KITTY HAWK, NC 27949
---	---

(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	<p>Continued From page 12</p> <p>(5) Acceptable instructor training programs shall include but are not limited to presentation of:</p> <p>(A) understanding the adult learner;</p> <p>(B) methods for teaching content of the course;</p> <p>(C) methods for evaluating trainee performance; and</p> <p>(D) documentation procedures.</p> <p>(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.</p> <p>(7) Trainers shall teach a training program aimed at preventing, reducing and eliminating the need for restrictive interventions at least once annually.</p> <p>(8) Trainers shall complete a refresher instructor training at least every two years.</p> <p>(j) Service providers shall maintain documentation of initial and refresher instructor training for at least three years.</p> <p>(1) Documentation shall include:</p> <p>(A) who participated in the training and the outcomes (pass/fail);</p> <p>(B) when and where attended; and</p> <p>(C) instructor's name.</p> <p>(2) The Division of MH/DD/SAS may 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>	V 536		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL028-019	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/22/2019
--	---	---	---

NAME OF PROVIDER OR SUPPLIER CHANGING TIDES	STREET ADDRESS, CITY, STATE, ZIP CODE 3512 NORTH VIRGINIA DARE TRAIL KITTY HAWK, NC 27949
---	---

(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	<p>Continued From page 13</p> <p>This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 2 of 4 audited staff (the Administrator/Supervisor, and Therapist #1) received training in alternatives to restrictive interventions. The findings are:</p> <p>Finding #1: Review on 11/18/19 of the Administrator/Supervisor's personnel record revealed: - Hire date 4/13/17. - North Carolina Interventions training expired 3/31/18; no updated training in alternatives to restrictive interventions.</p> <p>Review on 11/18/19 of Therapist #1's personnel record revealed: - Hire date 8/16/19, title Substance Abuse Counselor. - No documented training in alternatives to restrictive interventions.</p> <p>During interview on 11/18/19 the Administrator/Supervisor stated no staff had up to date training in alternatives to restrictive interventions. She would schedule training for staff as required.</p>	V 536		