Division of Health Service Regulation

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLI	=1ED
		MHL041-911	B. WING		02/2	5/2020
NAME OF P	ROVIDER OR SUPPLIER		RESS, CITY, STA	TE ZIP CODE	1 02/2	5/2020
NAME OF T	TOVIDER OR SOLT LIER		RD STREET	11, 211 0001		
MERCY H	OME SERVICES II		ORO, NC 2740	13		
0.0.15	CHMMADV CT		1		NI.	0/5
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
V 000	INITIAL COMMENTS		V 000			
	An annual survey was Deficiencies were cite	s completed on 2/25/20. ed.				
	category: 10A NCAC	d for the following service 27G .5600C Supervised Developmental Disability.				
V 107	27G .0202 (A-E) Pers	sonnel Requirements	V 107			
	which: (1) specifies the competency, work exqualifications for the p (2) specifies the the position; (3) is signed by supervisor; and (4) is retained in	have a written job ector and each staff position e minimum level of education, perience and other				
	provides care or serve the facility: (1) is at least 18 (2) is able to read follow directions; (3) meets the macompetency, work exequalifications for the part (4) has no substant neglect listed on the part of	ad, write, understand and inimum level of education, perience, skills and other				

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

TITLE (X6) DATE

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STATEMENT	FOR DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		MHL041-911	B. WING		02/25/2020
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STA	TE, ZIP CODE	
MERCY H	OME SERVICES II		ARD STREET	12	
	CLIMMADV CT	ATEMENT OF DEFICIENCIES	BORO, NC 2740	PROVIDER'S PLAN OF CORREC	TION
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETE
V 107	7 Continued From page 1		V 107		
	upon the offense in rewhich the applicant is (d) Staff of a facility currently licensed, regaccordance with appl services provided. (e) A file shall be ma employed indicating the shall be material applications.	elationship to the job for applying. or a service shall be gistered or certified in icable state laws for the intained for each individual he training, experience and r the position, including			
	facility failed to assure #1) met the minimum position. The findings Review on 2/25/20 of revealed: -A job title of ParaproA hire date of 2/4/20 -No documentation of Interview on 2/25/20 of The Owner had required documentation that his school diploma;	ew and interviews, the e 1 of 1 current staff (staff level of education for his are: staff #1's personnel record fessional; feducation. with staff #1 revealed: lested he provide had received his high e documentation from the			
		with the Owner revealed:			

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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF COR	RECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
		MHL041-911	B. WING		02/25/2020
NAME OF PROVIDE	R OR SUPPLIER	STREET AD	DDRESS, CITY, STA	TE, ZIP CODE	
MERCY HOME S	EDVICES II	907 DILL	ARD STREET		
WERCT HOWE 3	EKVICES II	GREENS	BORO, NC 2740	03	
(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 CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE
V 107 Cont	inued From page	2	V 107		
of ed -She	lucation available had requested tl	there was no documentation e for staff #1; he staff provide the ximately a week prior.			
V 536 27E Int.	.0107 Client Righ	nts - Training on Alt to Rest.	V 536		
ALTE INTE (a) F pract to re: (b) F disable empl demo comp other which or inj prope (c) F base comp gathe (d) T inclu mean beha meth cours (e) F by ea annu (f) C provi	tices that emphasistrictive intervent Prior to providing polities, staff includoyees, students postrate compete pleting training in a strategies for craft the likelihood of ury to a person verty damage is provider agencies d on state competed on state competed in the training shall be training shall be trained to determine sections to determine sections. Formal refresher ach service provider ally). Sontent of the training the training shall be the surable testing (we wished to determine sections ally).	plement policies and size the use of alternatives ions. services to people with ding service providers, or volunteers, shall ence by successfully communication skills and eating an environment in f imminent danger of abuse with disabilities or others or			

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Division of Health Service Regulation

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 '	CONSTRUCTION	(X3) DATE SU COMPLE	
		MHL041-911	B. WING		02/2	5/2020
	ROVIDER OR SUPPLIER	907 DILL	DDRESS, CITY, STA ARD STREET BORO, NC 2740			
(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 CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
V 536	Paragraph (g) of this (g) Staff shall demon following core areas: (1) knowledge people being served; (2) recognizing behavior; (3) recognizing external stressors that disabilities; (4) strategies for relationships with per (5) recognizing organizational factors disabilities; (6) recognizing assisting in the perso decisions about their (7) skills in assescalating behavior; (8) communica and de-escalating por and (9) positive behaviors which are used to the communication of initiat least three years. (1) Documentation of initiat least three years. (1) Documentation of initiat least three years. (1) Documentation of initiat least three years. (2) The Division	Rule. strate competence in the and understanding of the and interpreting human the effect of internal and at may affect people with or building positive sons with disabilities; cultural, environmental and at that may affect people with the importance of and n's involvement in making life; essing individual risk for tion strategies for defusing tentially dangerous behavior; havioral supports (providing n disabilities to choose ly oppose or replace unsafe). Is shall maintain al and refresher training for tion shall include: ated in the training and the where they attended; and name; n of MH/DD/SAS may boumentation at any time.	V 536			

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Division of Health Service Regulation

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
		MHL041-911	B. WING		02/25/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
		907 DII I A	RD STREET		
MERCY H	OME SERVICES II		ORO, NC 2740	13	
			10,110 2/40		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
V 536	Continued From page	e 4	V 536		
V 536	(1) Trainers shaby scoring 100% on taimed at preventing, need for restrictive into (2) Trainers shaby scoring a passing instructor training pro (3) The training competency-based, in objectives, measurable observation of behavior measurable methods failing the course. (4) The content service provider plans approved by the Divist to Subparagraph (i) (5) Acceptable shall include but are roundered (A) understandi (B) methods for course; (C) methods for performance; and (D) documentate (6) Trainers shateaching a training proveducing and eliminating interventions at least review by the coach. (7) Trainers shate aimed at preventing, need for restrictive intannually.	all demonstrate competence esting in a training program reducing and eliminating the terventions. all demonstrate competence grade on testing in an gram. g shall be neclude measurable learning le testing (written and by ior) on those objectives and to determine passing or t of the instructor training the sto employ shall be sion of MH/DD/SAS pursuant io of this Rule. instructor training programs not limited to presentation of: ng the adult learner; r teaching content of the r evaluating trainee ion procedures. all have coached experience orgam aimed at preventing, ting the need for restrictive one time, with positive all teach a training program reducing and eliminating the terventions at least once all complete a refresher east every two years.	V 536		
	• ,	al and refresher instructor			

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED
		MHL041-911	B. WING		02	2/25/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	E. ZIP CODE		
			ARD STREET	,		
MERCY H	OME SERVICES II	GREENS	SBORO, NC 27403			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
V 536	(A) who particip outcomes (pass/fail); (B) when and w (C) instructor's (2) The Divisior request and review th (k) Qualifications of (1) Coaches sh requirements as a tra (2) Coaches sh the course which is be (3) Coaches sh competence by comp train-the-trainer instru	entation shall include: ated in the training and the where attended; and name. n of MH/DD/SAS may is documentation any time. Coaches: all meet all preparation iner. all teach at least three times eing coached. all demonstrate letion of coaching or	V 536			
	on Alternatives to Res annually. The findings Review on 2/25/20 of revealed:	ew and interviews, the e 1 of 1 Qualified d a formal refresher training strictive Interventions				
		3; at training on Alternatives to ns had been completed				

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Division of Health Service Regulation

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED
		MHL041-911	B. WING		02	/25/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	, ZIP CODE		
MERCY H	OME SERVICES II		LARD STREET SBORO, NC 27403			
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
V 536	-She had missed the Restrictive Intervention January 2020 due to -She was aware that be taken at least anni-She had been waiting another training. Interview on 2/25/20 she was aware the total training on Alternative Interventions that was due to sickness; -She had informed the ago that she needed immediately; -She was not aware to sickness.	with the QP revealed: training on Alternatives to ons that was scheduled in sickness; the training was required to ually; g on the Owner to schedule with the Owner revealed: he QP had not attended the es to Restrictive s scheduled in January 2020 e QP approximately a week to complete the training	V 536			
V 537	ITO 10A NCAC 27E .0108 SECLUSION, PHYSI ISOLATION TIME-OU (a) Seclusion, physic time-out may be emp been trained and hav competence in the pr to these procedures. staff authorized to em procedures are retrai competence at least a (b) Prior to providing disabilities whose trea	CAL RESTRAINT AND JT ral restraint and isolation loyed only by staff who have e demonstrated oper use of and alternatives Facilities shall ensure that aploy and terminate these ned and have demonstrated annually. direct care to people with atment/habilitation plan terventions, staff including	V 537			

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STATE FORM 6899 7TYU11 If continuation sheet 7 of 12

Division of Health Service Regulation

DIVISION	i Health Service Negu	iauon			1	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION		CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	A. BUILDING:		ETED
			B. WING		00/0	
		MHL041-911	D. WING		02/2	5/2020
NAME OF PR	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		907 DILL	RD STREET			
MERCY H	OME SERVICES II			20		
		GREENSE	ORO, NC 2740	J3 		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO		(X5)
PREFIX TAG	•	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI		COMPLETE DATE
IAG		,	1/40	DEFICIENCY)		
V 537	Continued From page	e 7	V 537			
	valuntoors shall comm	olete training in the use of				
		estraint and isolation time-out				
		se interventions until the				
	training is completed	and competence is				
	demonstrated.					
		r taking this training is				
		etence by completion of				
	• •	, reducing and eliminating				
	the need for restrictive					
		be competency-based,				
	include measurable le					
	- ,	vritten and by observation of				
	•	ejectives and measurable				
	methods to determine	e passing or failing the				
	course.					
	(e) Formal refresher	training must be completed				
	by each service provi	der periodically (minimum				
	annually).					
	(f) Content of the trai	ning that the service				
	provider plans to emp	ploy must be approved by				
	the Division of MH/DI	D/SAS pursuant to				
	Paragraph (g) of this	Rule.				
		ng programs shall include,				
	but are not limited to,	· · ·				
		formation on alternatives to				
	the use of restrictive i	interventions;				
		on when to intervene				
		nent danger to self and				
	others);	.o danigor to oon ama				
	•	n safety and respect for the				
		ill persons involved (using				
		rictive interventions and				
	incremental steps in a					
	-	or the safe implementation				
	of restrictive intervent					
		emergency safety				
	(5) the use of e interventions which in					
		itoring of the physical and				
	psychological well-be	ing of the client and the safe				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SI COMPLE	
		MHL041-911	B. WING		02/2	5/2020
	ROVIDER OR SUPPLIER	907 DILLAF	RESS, CITY, STA RD STREET DRO, NC 2740			
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
V 537	restrictive intervention (6) prohibited p (7) debriefing s importance and purpo (8) documentat (h) Service providers documentation of initi at least three years. (1) Documenta (A) who particip outcomes (pass/fail); (B) when and w (C) instructor's (2) The Division review/request this do (i) Instructor Qualificat Requirements: (1) Trainers sha by scoring 100% on to aimed at preventing, need for restrictive inf (2) Trainers sha by scoring 100% on to teaching the use of se and isolation time-out (3) Trainers sha by scoring a passing instructor training pro (4) The training competency-based, in objectives, measurab observation of behavi measurable methods failing the course. (5) The content service provider plans	ghout the duration of the n; rocedures; trategies, including their ose; and ion methods/procedures. shall maintain al and refresher training for tion shall include: ated in the training and the where they attended; and name. In of MH/DD/SAS may ocumentation at any time. Action and Training all demonstrate competence esting in a training program reducing and eliminating the terventions. In all demonstrate competence esting in a training program reducing and eliminating the terventions. In all demonstrate competence esting in a training program eclusion, physical restraint in all demonstrate competence grade on testing in an an orgam. In shall be include measurable learning le testing (written and by or) on those objectives and to determine passing or the instructor training the sit to employ shall be sit on of MH/DD/SAS pursuant	V 537			

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	,
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
		MHL041-911	B. WING		02/25/202	:0
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		907 DILLA	ARD STREET			
MERCY H	OME SERVICES II	GREENSI	BORO, NC 2740	03		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	I ((X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE COM	MPLETE DATE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IAIE	AIE
\/ 507	0 " 15	0	V 507			
V 537			V 537			
		instructor training programs				
	shall include, but not be limited to, presentation					
	of:					
		ng the adult learner;				
	• •	r teaching content of the				
	course; (C) evaluation of	of trainee performance; and				
	` ,	ion procedures.				
		all be retrained at least				
	()	trate competence in the use				
	<u>-</u>	restraint and isolation				
		in Paragraph (a) of this				
	Rule.	3 1 ()				
		all be currently trained in				
	CPR.	•				
	(9) Trainers sha	all have coached experience				
	•	restrictive interventions at				
		positive review by the				
	coach.					
	• •	all teach a program on the				
		ventions at least once				
	annually.	- U				
	• ,	all complete a refresher				
	instructor training at le (k) Service providers					
	` '	al and refresher instructor				
	training for at least the					
	_	tion shall include:				
	()	ated in the training and the				
	outcome (pass/fail);	.9				
		where they attended; and				
	(C) instructor's	-				
		n of MH/DD/SAS may				
	review/request this do	ocumentation at any time.				
	(I) Qualifications of C					
		all meet all preparation				
	requirements as a tra					
	-	all teach at least three				
	times, the course whi	ch is being coached.				

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STATEMENT	FOR DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		MHL041-911	B. WING		02/25/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE	
MERCY H	OME SERVICES II		ARD STREET	200	
	CHAMARYCT	ATEMENT OF DEFICIENCIES	BORO, NC 2740		u
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
V 537	Continued From page	e 10	V 537		
		nall demonstrate eletion of coaching or ection. Shall be the same			
	This Rule is not met as evidenced by: Based on record review and interviews the facility failed to assure 1 of 1 Qualified Professional (QP) had training in Seclusion, Physical Restraint and Isolation Time-Out at least annually. The findings are: Review on 2/25/20 of the QP's personnel file revealed: -A title of QP; -A hire date of 8/28/18; -No documentation that training in Seclusion, Physical Restraint and Isolation Time-Out had been completed since 1/29/19.				
	-She had missed the Physical Restraint an was scheduled in Jar -She was aware that be taken at least ann	d Isolation Time-Out that nuary 2020 due to sickness; the training was required to			
	-The facility was not r -She was aware the t training in Seclusion,	he QP had not attended the Physical Restraint and at was scheduled in January			

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S COMPL	
		MHL041-911	B. WING		02/2	25/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
MERCY H	OME SERVICES II		RD STREET ORO, NC 274(03		
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
V 537	-She had informed the ago that she needed immediately; -She was not aware to	e QP approximately a week to complete the training	V 537			

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