

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL092-535</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>03/05/2020</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>BLESSED HOME, LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>3113 EDGETONE DRIVE</b> <b>RALEIGH, NC 27604</b>
--	---

(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><b>INITIAL COMMENTS</b></p> <p>An annual and follow-up survey was completed 3/5/20. Deficiencies were cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities.</p>	V 000		
V 536	<p>27E .0107 Client Rights - Training on Alt to Rest. Int.</p> <p><b>10A NCAC 27E .0107 TRAINING ON ALTERNATIVES TO RESTRICTIVE INTERVENTIONS</b></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 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</p>	V 536		

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:  <b>MHL092-535</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  R <b>03/05/2020</b>
--	---	---	--

NAME OF PROVIDER OR SUPPLIER  <b>BLESSED HOME, LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>3113 EDGETONE DRIVE RALEIGH, NC 27604</b>
--	---

(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 1</p> <p>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"> <li>(1) knowledge and understanding of the people being served;</li> <li>(2) recognizing and interpreting human behavior;</li> <li>(3) recognizing the effect of internal and external stressors that may affect people with disabilities;</li> <li>(4) strategies for building positive relationships with persons with disabilities;</li> <li>(5) recognizing cultural, environmental and organizational factors that may affect people with disabilities;</li> <li>(6) recognizing the importance of and assisting in the person's involvement in making decisions about their life;</li> <li>(7) skills in assessing individual risk for escalating behavior;</li> <li>(8) communication strategies for defusing and de-escalating potentially dangerous behavior; and</li> <li>(9) positive behavioral supports (providing means for people with disabilities to choose activities which directly oppose or replace behaviors which are unsafe).</li> </ol> <p>(h) Service providers shall maintain documentation of initial and refresher training for at least three years.</p> <ol style="list-style-type: none"> <li>(1) Documentation shall include: <ol style="list-style-type: none"> <li>(A) who participated in the training and the outcomes (pass/fail);</li> <li>(B) when and where they attended; and</li> <li>(C) instructor's name;</li> </ol> </li> <li>(2) The Division of MH/DD/SAS may review/request this documentation at any time.</li> </ol>	V 536		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL092-535</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>03/05/2020</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>BLESSED HOME, LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>3113 EDGETONE DRIVE</b> <b>RALEIGH, NC 27604</b>
--	---

(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 2</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> <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</p>	V 536		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL092-535</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>03/05/2020</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>BLESSED HOME, LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>3113 EDGETONE DRIVE</b> <b>RALEIGH, NC 27604</b>
--	---

(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 3</p> <p>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> <p> </p> <p>This Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure one of one staff (#1) had annual training for Alternatives to Restrictive Interventions. The findings are:</p> <p> </p> <p>Review on 3/4/20 of staff #1's record revealed: -Hire date of 10/23/14. -Training in Alternative to Restrictive Interventions completed on 3/29/18.</p> <p> </p> <p>During interview on 3/4/20 the Licensee stated: -Had been having a difficult time getting up</p>	V 536		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL092-535</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>03/05/2020</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>BLESSED HOME, LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>3113 EDGETONE DRIVE</b> <b>RALEIGH, NC 27604</b>
--	---

(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	Continued From page 4  with a trainer to complete training for staff. -Had used the same trainer for North Carolina Interventions (NCI) over the years and he had not returned her calls in the last few months to schedule training. -Had reached out to other providers to obtain new trainers to use.	V 536		
V 736	27G .0303(c) Facility and Grounds Maintenance  10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS (c) Each facility and its grounds shall be maintained in a safe, clean, attractive and orderly manner and shall be kept free from offensive odor.  This Rule is not met as evidenced by: Based on observation and interview the facility failed to maintain the facility in a safe, attractive manner. The findings are:  Observation on 3/4/20 at 11:30 AM: -Smoke detector in eating area chirping. -Client bathroom had large areas of black mildew on the ceiling. -Client bathroom sink faucet was spraying water out of the side area when running.  During interview on 3/4/20 Staff #1 stated: -She had not noticed the chirping from smoke detector, "It must have just started." -Not aware of the bathroom ceiling having mold. -Not aware of the faucet having any issues.	V 736		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL092-535</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>03/05/2020</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>BLESSED HOME, LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>3113 EDGETONE DRIVE</b> <b>RALEIGH, NC 27604</b>
--	---

(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 736	Continued From page 5  -Will let the Licensee's husband know of the repairs to be completed.	V 736		