SPT

PRINTED: 03/11/2020
FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL001-014	A. BUILDING: _____ B. WING _____	R 03/06/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRESTVIEW GROUP HOME #2	635 CRESTVIEW DRIVE BURLINGTON, NC 27217

(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 and follow-up survey was completed on March 6, 2020. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600 A Supervised Living for Adults with Mental Illness.	V 000		
V 108	27G .0202 (F-I) Personnel Requirements 10A NCAC 27G .0202 PERSONNEL REQUIREMENTS (f) Continuing education shall be documented. (g) Employee training programs shall be provided and, at a minimum, shall consist of the following: (1) general organizational orientation; (2) training on client rights and confidentiality as delineated in 10A NCAC 27C, 27D, 27E, 27F and 10A NCAC 26B; (3) training to meet the mh/dd/sa needs of the client as specified in the treatment/habilitation plan; and (4) training in infectious diseases and bloodborne pathogens. (h) Except as permitted under 10a NCAC 27G .5602(b) of this Subchapter, at least one staff member shall be available in the facility at all times when a client is present. That staff member shall be trained in basic first aid including seizure management, currently trained to provide cardiopulmonary resuscitation and trained in the Heimlich maneuver or other first aid techniques such as those provided by Red Cross, the American Heart Association or their equivalence for relieving airway obstruction. (i) The governing body shall develop and implement policies and procedures for identifying, reporting, investigating and controlling infectious	V 108	V108: In order to correct the cited, a CPR training for cited deficient staff has been scheduled for March 7, 2020. To prevent the cited from recurring, the HR director will ensure that all new staff will have appropriate trainings scheduled upon date of hire. The Group Home Manager will ensure that new staff will not be scheduled to work unsupervised until necessary trainings are complete. Records of trainings will otherwise be reviewed on a 6 month basis to monitor expiration dates and potential lapses. DHSR-Mental Health MAR 2 5 2020 Lic. & Cert. Section	5/5/2020

Division of Health Service Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Jane Stem | Hall Avenue Manager | 3-19-20

STATE FORM 6899 M5S711 If continuation sheet 1 of 15

Carolyn E. Carter M.D. CCSLAS
Clinical Director

3-19-20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL001-014	A. BUILDING: _____ B. WING _____	R 03/06/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRESTVIEW GROUP HOME #2	635 CRESTVIEW DRIVE BURLINGTON, NC 27217

(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 108	Continued From page 1 and communicable diseases of personnel and clients. This Rule is not met as evidenced by: Based on interview and record review, the facility management failed to assure that all staff who work alone with clients are trained in basic first aid including seizure management, currently trained to provide cardiopulmonary resuscitation (CPR) and trained in the Heimlich maneuver or other first aid techniques affecting 1 of 3 audited direct care staff (#1). The findings are: Review on 3/6/20 of Staff #1's personnel file revealed the following information; -- Date of hire 12/29/19. -- Position of paraprofessional. -- Working schedule every other weekend, 16 hour shifts (2 shifts). -- No documentation of CPR or First Aid training. Interview on 3/6/20 with the Human Resources staff revealed the following information; -- Staff #1 was "a new staff." -- Staff #1 had not yet been scheduled for the required CPR and First Aid training due to being "a new staff." -- She was not aware that there must be a staff on duty at all times trained in CPR and First Aid. Review on 3/4/20 of all of the current client's records (Clients #1, #2 and #3) revealed each of them to have a diagnoses of Hypertension (high blood pressure). -- Client #1 and Client #3 are both prescribed and	V 108		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL001-014	A. BUILDING: _____ B. WING _____	R 03/06/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRESTVIEW GROUP HOME #2	635 CRESTVIEW DRIVE BURLINGTON, NC 27217

(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 108	Continued From page 2 administered 2 separate medications to control elevated blood pressure and heart disease. -- Client #1 has a history of a Stroke in 2016. -- Client #2 is prescribed and administered 3 separate medications to control elevated blood pressure and heart disease.	V 108		
V 112	27G .0205 (C-D) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (c) The plan shall be developed based on the assessment, and in partnership with the client or legally responsible person or both, within 30 days of admission for clients who are expected to receive services beyond 30 days. (d) The plan shall include: (1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement; (2) strategies; (3) staff responsible; (4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both; (5) basis for evaluation or assessment of outcome achievement; and (6) written consent or agreement by the client or responsible party, or a written statement by the provider stating why such consent could not be obtained.	V 112	V112: To correct the cited, the clients' clinical homes will be consulted regarding attainability of identified goals and effective strategies to achieve them. In order to prevent the cited from recurring, the Group Home Manager will attend treatment plan appointments with the cited clients to ensure that the plan is well defined, appropriate, and understood. The Group Home Manager will be responsible for ensuring that treatment plans are effective and adhered to by staff and the consumer.	5/5/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL001-014	A. BUILDING: _____ B. WING _____	R 03/06/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRESTVIEW GROUP HOME #2	635 CRESTVIEW DRIVE BURLINGTON, NC 27217

(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 112	Continued From page 3 This Rule is not met as evidenced by: Based on interview and record review, the facility management failed to develop and implement strategies and interventions to address identified needs affecting 2 of 3 audited clients (#1 #2). The findings are: A. Review on 3/3/20 of Client #1's record revealed the following information; -- 67 year old female. -- Admitted to the facility on 3/5/18. -- Diagnoses include Chronic Paranoid Schizophrenia, Mild Dementia, Pseudocyesis (a condition in which the patient has all signs and symptoms of pregnancy except for the confirmation of the presence of a fetus), Diabetes Mellitus Type II, Hypertension, Anemia, Hyperlipidemia, Constipation, Gastroesophageal Reflux Disease, Hepatitis, Hemorrhoids and Degenerative Disc Disease. -- History of a Stroke in 2016. -- Had an Abdominal Ultrasound on 9/25/19 with a negative result for any conditions/problems/pregnancy. Review on 3/4/20 of Client #1's record revealed the following instances of Emergency Room (ER) use for various reasons; -- 3/4/19 - ER for nausea, vomiting and back pain. Admitted to the psychiatric unit and discharged on 3/12/19. -- 3/14/19 - ER for nausea, vomiting and dehydration. -- 5/7/19 - ER for hip and back pain. -- 6/28/19 - ER for abdominal pain. -- 9/8/19 - ER for abdominal bloating. -- 9/29/19 - ER for weakness, nausea and cough. -- 10/21/19 - ER for back and hip pain. -- 2/1/20 - ER for falling and abdominal pain.	V 112		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL001-014	A. BUILDING: _____ B. WING _____	R 03/06/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRESTVIEW GROUP HOME #2	635 CRESTVIEW DRIVE BURLINGTON, NC 27217

(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 112	Continued From page 4 Review on 3/6/20 of Client #1's current treatment plan dated 4/9/19 revealed the following no goals/strategies/interventions aimed at reducing the use of ERs due to the belief that she is pregnant. B. Review on 3/4/20 of Client #2's record revealed the following information; -- 46 year old female. -- Admitted to the facility on 8/18/10. -- Diagnoses include Schizophrenia, Diabetes Mellitus Type II, Hypertension, Polycystic Ovarian Disease, Obesity, Hypothyroidism, Hyperlipidemia and Chronic Knee Pain. -- An FL-2 dated 8/26/19 with a Physician's order for the client to check her blood sugars twice a day. Review on 3/6/20 of Client #2's blood sugar readings (morning and evening) by month revealed the following information; -- January 2020, blood sugars ranged from 152 to 423. -- February 2020, blood sugars ranged from 199 to 575. -- March 2020 (6 days total), blood sugars ranged from 162 to 434. (Normal blood sugar levels are less than 100 after not eating (fasting) for at least eight hours. And less than 140 two hours after eating.) Review on 3/6/20 of Client #2's A1-c levels (a blood test to measure levels that are reflective of how well diabetes is controlled) revealed the following information; 8/27/19 - an A1-c level of 8.6 2/20/20 - an A1-c level of 9.6 (A1-c levels are as follows: Normal Below 6.0	V 112		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL001-014	A. BUILDING: _____ B. WING _____	R 03/06/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRESTVIEW GROUP HOME #2	635 CRESTVIEW DRIVE BURLINGTON, NC 27217

(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 112	Continued From page 5 Prediabetic 6.0 to 6.4 Diabetic 6.5 or over. The higher your A1-c level, the poorer your blood sugar control and the higher your risk of Diabetes complications.) Additional review on 3/6/20 of Client #2's record revealed the following information; -- Her weight on 1/28/20 was 287 pounds (high weight increases complications of Diabetes). -- An FL-2 dated 8/26/19 with a Physician's order for a low sugar therapeutic diet. -- She is being prescribed and administered 2 separate kinds of Insulin (Lantus and Byetta). -- She is being prescribed and administered 2 separate kinds of oral antidiabetic medications (Metformin and Glipizide). Review on 3/6/20 of Client #2's current treatment plan dated 4/10/19 revealed the following residential goals; -- Take medications as prescribed to maintain my Diabetes. -- Comply with dietary, nutritional and exercise programs to improve her Diabetes. HOW: "Staff will monitor her compliance with dietary and nutritional meals, exercise, and reduction in snack foods." -- No specific strategies or interventions to address the client's non-compliance with treatment recommendations to control or lower her blood sugar readings. Interview on 3/6/20 with the Group Home Manager revealed no additional information.	V 112		
V 121	27G .0209 (F) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS	V 121		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL001-014	A. BUILDING: _____ B. WING _____	R 03/06/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRESTVIEW GROUP HOME #2	635 CRESTVIEW DRIVE BURLINGTON, NC 27217

(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 121	Continued From page 6 (f) Medication review: (1) If the client receives psychotropic drugs, the governing body or operator shall be responsible for obtaining a review of each client's drug regimen at least every six months. The review shall be to be performed by a pharmacist or physician. The on-site manager shall assure that the client's physician is informed of the results of the review when medical intervention is indicated. (2) The findings of the drug regimen review shall be recorded in the client record along with corrective action, if applicable. This Rule is not met as evidenced by: Based on interview and record review, the facility failed to assure that a 6 month medication regimen review was conducted every 6 months for clients being prescribed psychotropic medications affecting 3 of 3 current clients (#1 #2 #3). The findings are: Review on 3/3/20 of Client #1's record revealed the following information; -- 67 year old female. -- Admitted to the facility on 3/5/18. -- Diagnoses include Chronic Paranoid Schizophrenia, Mild Dementia, Pseudocyesis (a condition in which the patient has all signs and symptoms of pregnancy except for the confirmation of the presence of a fetus), Diabetes Mellitus Type II, Hypertension, Anemia, Hyperlipidemia, Constipation, Gastroesophageal Reflux Disease, Hepatitis, Hemorrhoids and Degenerative Disc Disease. -- Psychotropic medications being administered to Client #1 include Lithium Carbonate (for mood disorders), Clozaril (for Psychosis) and	V 121	V121: To correct the cited, a medication regimen review has been scheduled for 3/13/2020. To prevent the cited from recurring, the Group Home Manager will ensure that all 6 month medication regimen reviews are scheduled no later than 3 months in advance to avoid any scheduling issues.	4/5/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL001-014	A. BUILDING: _____ B. WING _____	R 03/06/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRESTVIEW GROUP HOME #2	635 CRESTVIEW DRIVE BURLINGTON, NC 27217

(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 121	Continued From page 7 Trazadone (for Depression and to aid in sleep). -- Last 6 month medication review dated 1/30/19. Review on 3/4/20 of Client #2's record revealed the following information; -- 46 year old female. -- Admitted to the facility on 8/18/10. -- Diagnoses include Schizophrenia, Diabetes Mellitus Type II, Hypertension, Polycystic Ovarian Disease, Obesity, Hypothyroidism, Hyperlipidemia and Chronic Knee Pain. -- Psychotropic medications being administered to Client #2 include Abilify (for mood disorders) and Klonopin (for Anxiety). -- Last 6 month medication review dated 1/30/19. Review on 3/4/20 of Client #3's record revealed the following information; -- 55 year old female. -- Admitted to the facility on 4/17/14. -- Diagnoses include Paranoid Schizophrenia, Bipolar Disorder with Psychotic Features, Alcohol Dependence - In Remission, Nicotine Dependence, Hypertension, Hyperthyroidism, Gastroesophageal Reflux Disease and Chronic Obstructive Pulmonary Disease. -- Psychotropic medications being administered to Client #3 include Ativan (for Anxiety), Zyprexa (for Psychosis), Lamictal (for mood disorders), Remeron (for Depression), Ingrezza (for psychiatric medication side effects) and Cogentin (for psychiatric medication side effects). -- Last 6 month medication review dated 1/30/19. Interview on 3/6/20 with the Group Home Manager revealed that the Pharmacy had been backed up on providing this service due to a death at the Pharmacy. This deficiency constitutes a re-cited deficiency	V 121		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL001-014	A. BUILDING: _____ B. WING _____	R 03/06/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRESTVIEW GROUP HOME #2	635 CRESTVIEW DRIVE BURLINGTON, NC 27217

(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 121	Continued From page 8 and must be corrected within 30 days.	V 121		
V 291	27G .5603 Supervised Living - Operations 10A NCAC 27G .5603 OPERATIONS (a) Capacity. A facility shall serve no more than six clients when the clients have mental illness or developmental disabilities. Any facility licensed on June 15, 2001, and providing services to more than six clients at that time, may continue to provide services at no more than the facility's licensed capacity. (b) Service Coordination. Coordination shall be maintained between the facility operator and the qualified professionals who are responsible for treatment/habilitation or case management. (c) Participation of the Family or Legally Responsible Person. Each client shall be provided the opportunity to maintain an ongoing relationship with her or his family through such means as visits to the facility and visits outside the facility. Reports shall be submitted at least annually to the parent of a minor resident, or the legally responsible person of an adult resident. Reports may be in writing or take the form of a conference and shall focus on the client's progress toward meeting individual goals. (d) Program Activities. Each client shall have activity opportunities based on her/his choices, needs and the treatment/habilitation plan. Activities shall be designed to foster community inclusion. Choices may be limited when the court or legal system is involved or when health or safety issues become a primary concern. This Rule is not met as evidenced by: Based on interview and record review, the facility	V 291	V291: To correct the cited, the Group Home Manager will schedule appointments with the cited clients' physicians with the intent of correcting and updating the deficient FL2s. To prevent the cited from recurring, the Group Home Manager will review FL2 documents to ensure that all medication dosages and regimens are correctly transcribed. To further ensure correct transcription of medications to FL2s, a representative from Medical Village Apothecary will be consulted prior to FL2 update appointments. When attending FL2 update appointments, the Group Home Manager will clarify the ability of the facility to accomodate physician ordered dietary restrictions to determine if a change in orders is necessary or if a physician suggestion is sufficient.	5/5/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL001-014	A. BUILDING: _____ B. WING _____	R 03/06/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRESTVIEW GROUP HOME #2	635 CRESTVIEW DRIVE BURLINGTON, NC 27217

(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 291	Continued From page 9 management failed to assure that service coordination was maintained between the facility operator and the Qualified Professionals (QPs) responsible for medical treatment affecting 2 of 3 current clients (#1 #2). The findings are: A. Review on 3/3/20 of Client #1's record revealed the following information; -- 67 year old female. -- Admitted to the facility on 3/5/18. -- Diagnoses include Chronic Paranoid Schizophrenia, Mild Dementia, Pseudocyesis (a condition in which the patient has all signs and symptoms of pregnancy except for the confirmation of the presence of a fetus), Diabetes Mellitus Type II, Hypertension, Anemia, Hyperlipidemia, Constipation, Gastroesophageal Reflux Disease, Hepatitis, Hemorrhoids and Degenerative Disc Disease. -- An FL-2 dated 2/20/20 with a Physician's order for a low carbohydrate, low salt therapeutic diet. Interview on 3/6/20 with the Group Home Manager revealed the following information; -- The facility does not serve Client #1 the ordered therapeutic diet. -- No one had advised the client's Physician that this order for a specific therapeutic diet could not be enforced. B. Review on 3/4/20 of Client #2's record revealed the following information; -- 46 year old female. -- Admitted to the facility on 8/18/10. -- Diagnoses include Schizophrenia, Diabetes Mellitus Type II, Hypertension, Polycystic Ovarian Disease, Obesity, Hypothyroidism, Hyperlipidemia and Chronic Knee Pain. -- An FL-2 dated 8/26/19 with a Physician's order for a low sugar therapeutic diet.	V 291		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL001-014	A. BUILDING: _____ B. WING _____	R 03/06/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRESTVIEW GROUP HOME #2	635 CRESTVIEW DRIVE BURLINGTON, NC 27217

(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 291	Continued From page 10 -- Physician's medication orders on the FL-2 dated 8/26/19 for Synthroid 10 mg. every day and Metformin 100 mg. twice a day. Interview on 3/6/20 with the Group Home Manager revealed the following information; -- The facility does not serve Client #2 the ordered therapeutic diet. -- No one had advised the client's Physician that this order for a specific therapeutic diet could not be enforced. -- She had filled out medication section of the FL-2 dated 8/26/19 and wrote the incorrect orders for Synthroid and Metformin (Synthroid is not available in 10 mg. doses and Metformin is not available in 100 mg. doses). -- She was not aware of the incorrect medication orders for the Synthroid or Metformin, therefore did not contact the Physician for clarification.	V 291		
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	V 536	V536: To correct the cited, an NCI Plus training has been scheduled for 3/11/2020. To prevent the cited from recurring, the HR Director will ensure that all new staff will have appropriate training scheduled upon date of hire. The Group Home Manager will ensure that new staff will not be scheduled to work unsupervised until necessary trainings are complete. Records of trainings will otherwise be reveiwed on a 6 month basis to monitor expiration dates and potential lapses.	5/5/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL001-014	A. BUILDING: _____ B. WING _____	R 03/06/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRESTVIEW GROUP HOME #2	635 CRESTVIEW DRIVE BURLINGTON, NC 27217

(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 11 based on state competencies, monitor for internal compliance and demonstrate they acted on data 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	V 536		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL001-014	A. BUILDING: _____ B. WING _____	R 03/06/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRESTVIEW GROUP HOME #2	635 CRESTVIEW DRIVE BURLINGTON, NC 27217

(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 12 means for people with disabilities to choose 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. (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	V 536		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL001-014	A. BUILDING: _____ B. WING _____	R 03/06/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRESTVIEW GROUP HOME #2	635 CRESTVIEW DRIVE BURLINGTON, NC 27217

(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 13 (D) documentation procedures. (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. (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.	V 536		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL001-014	A. BUILDING: _____ B. WING _____	R 03/06/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRESTVIEW GROUP HOME #2	635 CRESTVIEW DRIVE BURLINGTON, NC 27217

(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 14 This Rule is not met as evidenced by: Based on interview and record review, the facility management failed to assure that all staff had current training on Alternatives to Restrictive Interventions affecting 1 of 3 audited direct care staff (#1). The findings are: Review on 3/6/20 of Staff #1's personnel file revealed the following information; -- Date of hire 12/29/19. -- Position of paraprofessional. -- Working schedule every other weekend, 16 hour shifts (2 shifts). -- No documentation of any Alternatives to Restrictive Intervention training. Interview on 3/6/20 with the Human Resources staff revealed the following information; -- Staff #1 was "a new staff." -- Staff #1 had not yet been scheduled for the required training on Alternatives to Restrictive Interventions due to being "a new staff." -- She was not aware that all staff must have current training on Alternatives to Restrictive Interventions.	V 536		

Residential Treatment Services of Alamance, Inc.

P. O. Box 427
Burlington, North Carolina 27216-0427
EIN: 56-0988222

Administrative Office 336-227-2994
Administrative Office Fax 336-227-2996
Crestview Men's Facility 336-227-1911
Crestview Women's Facility 336-222-1737

Hall Avenue Facility 336-227-7417
Hall Avenue Facility Fax 336-227-4010
Mebane Street Facility 336-227-4256
Trollinger Treasures 336-227-8500

March 19, 2020

To: Mental Health Licensure and Certification Section
NC Division of Health Service Regulation

From: Carolyn E.Carter, M.Ed., CCS, LCAS
Clinical Director

Re: Plan of Correction for Crestview Group Homes

Enclosed you will find the Plan Of Correction for our Crestview Group Homes.

Thanking You In Advance.

Carolyn E. Carter