PRINTED: 01/21/2020 FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER-COMPLETED A. BUILDING: R B. WING MHL026-658 01/10/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 334 MOORE STREET CAROL'S DDA GROUP HOME **FAYETTEVILLE, NC 28301** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) V 000 INITIAL COMMENTS V 000 The facility has reviewed and revised 01/15/2020 An annual and follow up survey was completed its Policy and Procedure to ensure all Ongoing on January 10, 2020. Deficiencies were cited. rules are followed and implemented as required for facility to remain in This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised compliance. Living for Adults with Developmental Disabilities. RECEIVED V 114 27G .0207 Emergency Plans and Supplies V 114 APR 2 7 2020 10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES **DHSR-MH Licensure Sect** (a) A written fire plan for each facility and DHSR-MH Licensure Sect area-wide disaster plan shall be developed and shall be approved by the appropriate local authority. (b) The plan shall be made available to all staff and evacuation procedures and routes shall be posted in the facility. (c) Fire and disaster drills in a 24-hour facility shall be held at least quarterly and shall be repeated for each shift. Drills shall be conducted under conditions that simulate fire emergencies. (d) Each facility shall have basic first aid supplies accessible for use. The Residential manager, all staff and 01/15/2020 administrator will review fire and Ongoing

This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure fire and disaster drills were held quarterly and repeated on each shift. The findings

During interview on 01/08/2020 the Licensee revealed the shifts of the facility were:

- -First shift 7:00am-3:00pm
- -Second shift 3:00pm-11:00pm
- -Third shift 11:00pm-7:00am

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

for each shift.

disaster drills are completed quarterly

(X6) DATE

STATE FORM

If continuation sheet

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING			
		MHL026-658	B. WING		R 01/10/2020	
NAME OF	PROVIDER OR SUPPLIER	STREET ADD	ORESS, CITY, S	TATE, ZIP CODE		
CAROL'S	DDA GROUP HOME		E STREET	204		
CANID	SI IMMARY STA	ATEMENT OF DEFICIENCIES	ILLE, NC 28			_
(X4) ID PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETE	
V 114	Continued From page	1	· V 114			
V 131	January 2019 thru Dec-No 2nd or 3rd shift fir 2019.  No 2nd shift fire drill -No 3rd shift disaster of 2019.  No 3rd shift disaster of 2019.  No 1st or 3rd shift disaster of 2019.  No 1st or 3rd shift disaster of 2019.  During interview on 1/2 #6 revealed they compate the facility.  Interview on 01/08/202-The clients were not in due to being in day pro-The facility had a live in She would ensure all ton each shift for every  This deficiency constitute and must be corrected.  G.S. \$131E-256 (D2) HOVerification.  G.S. \$131E-256 HEALTREGISTRY (d2) Before hiring healting	10/2020 clients #2, #4 and pleted fire and disaster drills 20 the Licensee stated: In the facility during the day agrams. In staff. Ithe drills were completed quarter. In the a re-cited deficiency within 30 days.  CPR - Prior Employment  TH CARE PERSONNEL	V 131			
	health care facility shall	access the Health Care shall note each incident				

PRINTED: 01/21/2020 FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER-COMPLETED A. BUILDING: R B. WING MHL026-658 01/10/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 334 MOORE STREET **CAROL'S DDA GROUP HOME FAYETTEVILLE, NC 28301** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) V 131 Continued From page 2 V 131 This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to document accessing the Health The HCPR will always be completed 01/15/2020 Care Personnel Registry (HCPR) prior to hiring 1 before hiring and will be printed and Ongoing of 2 staff (Staff #1). The findings are: placed in each staff file. Staff file will Review on 01/08/2020 of staff #1's record be reviewed to ensure all required revealed: information is completed on time. -Hire date 02/20/19. -The HCPR was not completed until 03/26/19. Interview on 01/08/2020 the Licensee revealed: -She would ensure the HCPR checks are completed before each hire. V 536 27E .0107 Client Rights - Training on Alt to Rest. V 536 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,

Division of Health Service Regulation

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

(c) Provider agencies shall establish training

property damage is prevented.

Division of Health Service Regulation STATEMENT OF DEFICIENCIES

(X1) PROVIDER/SUPPLIER/CLIA

		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	3:		PLETED	
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NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
CAROL'S	DDA GROUP HOME	334 MOOR					
		FAYETTEV	ILLE, NC 28	301		700 pg 1 pg 1 pg 2 pg 2 pg 2 pg 2 pg 2 pg 2	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES  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	(X5) COMPLETE DATE	
V 536	Continued From page	3	V 536				
	based on state comper compliance and demogathered.  (d) The training shall be include measurable learnesurable testing (with behavior) on those object measurable testing (with behavior provider wishes to empt the Division of MH/DD/Paragraph (g) of this R (g) Staff shall demonst following core areas:  (1) knowledge are people being served; (2) recognizing a behavior; (3) recognizing the external stressors that redisabilities; (4) strategies for relationships with person (5) recognizing corganizational factors the disabilities; (6) recognizing the assisting in the person's decisions about their life (7) skills in assess escalating behavior; (8) communication and de-escalating potentiand	etencies, monitor for internal instrate they acted on data be competency-based, arning objectives, ritten and by observation of ectives and measurable passing or failing the raining must be completed er periodically (minimum ing that the service oloy must be approved by SAS pursuant to ule. It is trate competence in the ind understanding of the ind interpreting human the effect of internal and may affect people with individual inguity in the individual inguity in the individual inguity in the importance of and involvement in making	V 536				
	(9) positive behav	rioral supports (providing					

Division	Division of Health Service Regulation					
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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NAME OF F	ROVIDER OR SUPPLIER		DRESS, CITY, ST.	ATE ZIP CODE	01/	10/2020
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CAROL'S	DDA GROUP HOME		/ILLE, NC 283	01		
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V 536	Continued From page	4	V 536			
	means for people with activities which directly behaviors which are used. (h) Service providers documentation of initiate least three years. (1) Documentation of initiate least three years. (1) Documentation of initiate least three years. (1) Documentation outcomes (pass/fail); (B) when and with the content of the provision of	in disabilities to choose by oppose or replace insafe). In shall maintain all and refresher training for attention shall include: attention at the training and the othere they attended; and name; in of MH/DD/SAS may be cumentation at any time. Attended in a training and eliminating the extension of the instructor training the instructor training or of the instructor training the to employ shall be on of MH/DD/SAS pursuant				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
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		WITE020-038			01/	10/2020
	ROVIDER OR SUPPLIER	STREET ADD		ATE, ZIP CODE		
CAROL'S	DDA GROUP HOME		ILLE, NC 28:	301		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE	
	(6) Trainers shateaching a training proceducing and elimination interventions at least of review by the coach. (7) Trainers shate aimed at preventing, represented for restrictive integranually. (8) Trainers shate instructor training at legion (j) Service providers and documentation of initiate training for at least three (1) Documer (A) who participate outcomes (pass/fail); (B) when and when the documentation of Coaches shate course which is being the course which is being train-the-trainer instruction.	on procedures.  Ill have coached experience orgam aimed at preventing, and the need for restrictive one time, with positive.  Ill teach a training program educing and eliminating the erventions at least once.  Ill complete a refresher ast every two years.  In and refresher instructor ee years.  Intation shall include:  Inted in the training and the organism and the training and the organism and	V 536			
	This Rule is not met as	s evidenced by:	NATION CONTRACTOR OF			

Division	of Health Service Regu	lation				RM APPROVED	
STATEME	NT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION	[(V2) D41	T OUR TO	
////	TOT CORRECTION	IDENTIFICATION NUMBER:	1	G:		E SURVEY IPLETED	
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		MHL026-658	3. WING_			R	
NAME OF	PROVIDER OR SUPPLIER	etoret a	ODDESS SITE		1 0	1/10/2020	
				STATE, ZIP CODE			
CAROL'	S DDA GROUP HOME		ORE STREET EVILLE, NC 28	9204			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES					
PREFIX	(EACH DEFICIENC)	MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S	ECTION	(X5)	
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE AF	PROPRIATE	DATE	
14.50				DEFICIENCY)			
V 537	Continued From page	9	V 537				
	(6) Acceptable i	nstructor training programs					
	shall include, but not b	e limited to, presentation	1				
	of:		1				
	(A) understandin	g the adult learner;					
		teaching content of the					
	course; (C) evaluation or	f toning a series					
		f trainee performance; and on procedures.					
		be retrained at least					
		rate competence in the use					
	of seclusion, physical r	estraint and isolation					
	time-out, as specified i	s specified in Paragraph (a) of this					
	Rule.						
	(8) Trainers shal CPR.	be currently trained in		,			
	(9) Trainers shall	have coached experience					
	in teaching the use of r	estrictive interventions at					
	least two times with a p	ositive review by the				1	
	coach. (10) Trainers shall	danah					
	use of restrictive interve	teach a program on the				1	
	annually.	endons at least once				1	
4, 2500		complete a refresher					
	instructor training at lea	st every two years.	1				
	(k) Service providers si	hall maintain					
1		and refresher instructor		1			
	training for at least three						
1		n shall include:					
1	<ul><li>(A) who participate outcome (pass/fail);</li></ul>	ed in the training and the					
		ere they attended; and					
	(C) instructor's na						
1		f MH/DD/SAS may		*		1	
1	review/request this docu						
1	<ol> <li>Qualifications of Coa</li> </ol>	ches:					
		meet all preparation					
1	requirements as a traine						
		teach at least three		*		1	
	times, the course which	is being coached.				1	
ision of Heal	h Service Regulation						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		_
		A. BUILDING	G:			
	MHL026-658	B. WING		01	R / <b>10/2020</b>	
NAME OF PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
CAROL'S DDA GROUP HOME		RE STREET				
	FAYETTE	VILLE, NC 28	301			
PREFIX (EACH DEFICIE	STATEMENT OF DEFICIENCIES INCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE	
restrictive interven (6) prohibite (7) debriefin importance and pu (8) documen (h) Service provide documentation of in at least three years (1) Documen (A) who partic outcomes (pass/fai (B) when and (C) instructor (2) The Divist review/request this (i) Instructor Qualiff Requirements: (1) Trainers is by scoring 100% or aimed at preventing need for restrictive (2) Trainers is by scoring 100% or teaching the use of and isolation time-of (3) Trainers is by scoring a passing instructor training pu (4) The trainin competency-based, objectives, measura observation of beha measurable method failing the course. (5) The conte- service provider plan	pughout the duration of the ion; d procedures; g strategies, including their rpose; and tation methods/procedures. It is shall maintain initial and refresher training for it. It is to shall include: It is pated in the training and the initial and refresher training and the initial demonstrate competence in testing in a training program is seclusion, physical restraint and the initial demonstrate competence in testing in a training program is seclusion, physical restraint and the initial demonstrate competence in grade on testing in an initial demonstrate competence in grade on testing in an initial demonstrate competence in grade on testing in an initial demonstrate competence in the initial demonstrate and by the initial and refresher training the	V 537				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING:		COMPLETED	
		MIN 000 000	B. WING		R	
		MHL026-658	D. WING_		01/10/2020	
NAME OF PROVIDER OR SUPPLIER STREET AS			RESS, CITY, ST	TATE, ZIP CODE		
CAROL'S	DDA GROUP HOME	334 MOOR	E STREET			
		FAYETTEV	ILLE, NC 283	301		
(X4) ID		ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION	1 1,001	
PREFIX TAG		SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR		
		-		DEFICIENCY)		
V 537	Continued From page	7	· V 537			
		lete training in the use of straint and isolation time-out				
		e interventions until the				
	training is completed a					
160	demonstrated.					
	(c) A pre-requisite for	taking this training is				
		tence by completion of				
		reducing and eliminating				
	the need for restrictive					
	(d) The training shall b		71			
	include measurable les					
		ritten and by observation of ectives and measurable				
	methods to determine					
	course.	passing or raining the				
		raining must be completed				
		ler periodically (minimum				
	annually).					
	(f) Content of the train					
		oy must be approved by				
	the Division of MH/DD/					
	Paragraph (g) of this R					
4250	but are not limited to, p	g programs shall include,				
		ormation on alternatives to				
	the use of restrictive in					
- [	(2) guidelines on	when to intervene				
	(understanding immine	ent danger to self and				
1	others);					
		safety and respect for the				
		persons involved (using				
	concepts of least restrictions in concepts					
	incremental steps in ar (4) strategies for	the safe implementation				
	of restrictive intervention	•				
1		nergency safety				
	interventions which incl					
	assessment and monitor	oring of the physical and		FI.		
		g of the client and the safe				
	- W					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	(X3) DATE SURVEY COMPLETED	
		MHL026-658	B. WING		R 01/10/2020
	ROVIDER OR SUPPLIER  DDA GROUP HOME	334 MOOF	ORESS, CITY, ST RE STREET VILLE, NC 283		
(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 APPROPR DEFICIENCY)	BE COMPLETE
V 536	failed to ensure an Alt Interventions training MH/DD/SAS was com (Staff #1). The finding Review on 01/08/2020 revealed:  - Hire date was 02/20 - No evidence of an A Intervention training completed.  During interview on 01 - He worked all the time - He was unsure of all completed.  During interview on 01 revealed:	and record review the facility ternative to Restrictive approved by the Division of apleted for one of two staff gs are:  O of staff #1's record  19. Iternative to Restrictive ompleted.  1/08/2020 staff #1 revealed: e and was a live in staff. the trainings he had	V 536		
V 537	27E .0108 Client Right ITO  10A NCAC 27E .0108 SECLUSION, PHYSIC ISOLATION TIME-OU (a) Seclusion, physicatime-out may be employed been trained and have competence in the proto these procedures. Is staff authorized to emprocedures are retrain competence at least a (b) Prior to providing disabilities whose treated	CAL RESTRAINT AND T al restraint and isolation byed only by staff who have de demonstrated uper use of and alternatives Facilities shall ensure that bloy and terminate these ed and have demonstrated unually. lirect care to people with trment/habilitation plan erventions, staff including	V 537		

Division of Health Service Regulation

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Division of Health Service Regulation  STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SU	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING: _			
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		MHL026-658		710 0005		
NAME OF PROVIDER OR SUPPL	IER	STREET ADD  334 MOOR	RESS, CITY, STAT	E, ZIP CODE		
CAROL'S DDA GROUP HO	WE		LLE, NC 2830	1		
(X4) ID SUMP	MARY ST	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
competence b	ches s y com er instr tation	hall demonstrate pletion of coaching or ruction. shall be the same	· V 537			
Based on reconfacility failed to received train and isolation of Review on 01 revealed:  -Hire date wanger and a revealed of the wanger and t	ord revolved or ensuring in stime-or 1/08/20 station raint and the four of stew or siew or sie	et as evidenced by: views and interviews, the ure one of two staff (Staff #1) seclusion, physical restraint ut. The findings are: 020 of staff #1's personnel file 020/19. of training in seclusion, and isolation time-out. 01/08/2020 staff #1 revealed: time and was a live in staff. all the trainings he had 01/08/2020 the Licensee e staff #1 received the training.		Facility will ensure NCI Train successfully completed. All s demonstrate their knowledge ability at training. All inform will be placed in their file to reviewed and monitored on a basis.	taff will and ation be	01/15/2020 Ongoing

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January 21, 2020 Please find enclosed Plan of Correction for Carol's Group Home, If I can be of further Assistance You muy reach me at (910) 323-2575-Garelyn Parker