

ACT

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL092-918</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  R <b>03/10/2020</b>
--	---	--	--

NAME OF PROVIDER OR SUPPLIER  <b>WESTERN WAKE TREATMENT CENTER, LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2172 NORTH SALEM STREET, SUITE 105 APEX, NC 27523</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	INITIAL COMMENTS  An annual and follow-up survey was completed on March 10, 2020. Deficiency cited.  This facility is licensed for the following service categories: 10A NCAC 27G .3600 Outpatient Opioid Treatment  The client census was 65.	V 000		
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 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	V 536		

*Robyn Mitchell*  
5/28/2020

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

JUN 02 2020

Lic. & Cert. Section

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL092-918</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>03/10/2020</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>WESTERN WAKE TREATMENT CENTER, LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2172 NORTH SALEM STREET, SUITE 105 APEX, NC 27523</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>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> <p>(1) knowledge and understanding of the people being served;</p> <p>(2) recognizing and interpreting human behavior;</p> <p>(3) recognizing the effect of internal and external stressors that may affect people with disabilities;</p> <p>(4) strategies for building positive relationships with persons with disabilities;</p> <p>(5) recognizing cultural, environmental and organizational factors that may affect people with disabilities;</p> <p>(6) recognizing the importance of and assisting in the person's involvement in making 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>	V 536		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL092-918</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>03/10/2020</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>WESTERN WAKE TREATMENT CENTER, LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2172 NORTH SALEM STREET, SUITE 105 APEX, NC 27523</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>(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> <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</p>	V 536		
-------	--	-------	--	--

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL092-918</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>03/10/2020</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>WESTERN WAKE TREATMENT CENTER, LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2172 NORTH SALEM STREET, SUITE 105 APEX, NC 27523</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>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> <p>This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to ensure the Licensed Practical Nurse (#1) had current training on the use of alternatives to restrictive interventions. The findings are:</p> <p>Review on 3/10/20 of the LPN #1's personnel record revealed:</p> <ul style="list-style-type: none"> <li>- Hired date of 6/11/17.</li> <li>- Alternative restrictive Intervention expired</li> </ul>	V 536	<p>Plan of Correction: The Licensed Practical Nurse( #1) was scheduled for use of alternatives to restrictive interventions training. The training was completed on March 25, 2020. A copy of the training completion certificate has been included.</p> <p>Annual trainings are scheduled by the Program Director. The completion of clinic trainings are monitored by the Program Director. This process will be completed at the time of staff members annual evaluation.</p>	
-------	--	-------	--	--

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL092-918</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>03/10/2020</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>WESTERN WAKE TREATMENT CENTER, LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2172 NORTH SALEM STREET, SUITE 105 APEX, NC 27523</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 4</p> <p>2/25/20.</p> <ul style="list-style-type: none"> <li>- There was no evidence of current training on the use of alternatives to restrictive interventions.</li> </ul> <p>Interview on 3/10/20 with the Regional Director and Program Manager revealed:</p> <ul style="list-style-type: none"> <li>-The facility trained staff on Evidence Based Protective Interventions (EBPI).</li> <li>-Confirmed LPN #1's previous training expired.</li> <li>-LPN#1 will be scheduled for EBPI training as soon as possible.</li> <li>-The Program Manager confirmed he was responsible for scheduling employees training.</li> </ul>	V 536		
-------	--	-------	--	--

# Evidence Based Protective Interventions



# EBPI

EVIDENCE BASED PROTECTIVE INTERVENTIONS

## PARTICIPANT

*This certifies that*

**SEBRENA BLACKNALL**

*has fulfilled all the requirements for competency in  
the Approved Restrictive Intervention Curriculum*

**EBPI INTERVENTIONS - PREVENT**

*SUBJECT TO ANNUAL CERTIFICATION*


  
PREVENT TRAINER

CERTIFICATION DATE: March 25, 2020

THIS CERTIFICATE EXPIRES ONE YEAR FROM THE CERTIFICATION DATE, AT THE END OF THAT MONTH, AND CANNOT EXCEED MARCH 31, 2021.

Document: 2020032529639

PRINTED: March 25, 2020

  
Richard McDonald CEO

Western Wake Treatment Center, LLC  
2172 North Salem Street, Suite 105  
Apex, North Carolina 27523

May 28, 2020

Frances Hicks  
Joe Corprew  
Mental Health Licensure and Certification Section  
NC Division of Health and Service Regulation  
2718 Mail Service Center  
Raleigh, NC 27669

Dear Ms. Hicks and Mr. Corprew,

Thank you for the opportunity to work with you and your department during the annual and follow-up survey for Western Wake Treatment Center.

I have enclosed the response to the standard level deficiency sited during that visit and the supporting documentation.

Sincerely,

A handwritten signature in cursive script that reads "Robyn Mitchell".

Robyn Mitchell, RN  
Regional Director  
Western Wake Treatment Center  
(252) 299-0378  
[rm@treatmentcenter.com](mailto:rm@treatmentcenter.com)