(X3) DATE SURVEY

Division of Health Service Regulation

(X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING:			COMPLETED					
		MHL0601227	B. WING		10/26/2020			
	ROVIDER OR SUPPLIER AS COTTAGE	6750 SAI		DRESS, CITY, STATE, ZIP CODE NT PETERS LANE, SUITE 300				
(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 I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)				
V 000	INITIAL COMMENTS		V 000					
	The complaint was ur (NC00170043) A defic	ciency was cited. I for the following service 27G 1900 Psychiatric						
V 537	27E .0108 Client Righ	ts - Training in Sec Rest &	V 537					
	ISOLATION TIME-OU (a) Seclusion, physic time-out may be employed been trained and have competence in the proto these procedures. Staff authorized to emprocedures are retrained to the procedures are retrained to procedures are retrained to providing of disabilities whose treating includes restrictive into service providers, empolytical results and shall not use the straining is completed and shall not use the straining is completed and shall not use the straining in preventing, the need for restrictive (d) The training shall linclude measurable testing (with the second shall be the same as training to the same as training the shall linclude measurable testing (with the second shall be the same as training the same	CAL RESTRAINT AND IT al restraint and isolation oyed only by staff who have e demonstrated oper use of and alternatives Facilities shall ensure that ploy and terminate these ned and have demonstrated annually. direct care to people with atment/habilitation plan erventions, staff including ployees, students or lete training in the use of straint and isolation time-out the interventions until the and competence is I taking this training is tence by completion of reducing and eliminating the interventions. The competency-based,						

(X2) MULTIPLE CONSTRUCTION

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

(X6) DATE TITLE

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:	
		7. BOILBING.		
	MHL0601227	B. WING	B. WING 10/3	
NAME OF PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE	
MERANCAS COTTAGE	6750 SAI	NT PETERS LAN	NE, SUITE 300	
MERANCAS COTTAGE	MATTHE	WS, NC 28105		
PREFIX (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 537 Continued From page	: 1	V 537		
methods to determine course. (e) Formal refresher by each service proviannually). (f) Content of the trait provider plans to empthe Division of MH/DE Paragraph (g) of this (g) Acceptable training but are not limited to, (1) refresher into the use of restrictive if (2) guidelines of (understanding imminothers); (3) emphasis of rights and dignity of a concepts of least rest incremental steps in a (4) strategies for of restrictive intervent (5) the use of einterventions which in assessment and mone psychological well-because of restraint through restrictive intervention (6) prohibited providers (7) debriefing simportance and purportance and purpo	training must be completed der periodically (minimum ning that the service alloy must be approved by D/SAS pursuant to Rule. Ing programs shall include, presentation of: formation on alternatives to interventions; on when to intervene tent danger to self and in safety and respect for the ll persons involved (using rictive interventions and an intervention); or the safe implementation ions; mergency safety clude continuous itoring of the physical and ing of the client and the safe ghout the duration of the it; rocedures; trategies, including their ose; and ion methods/procedures.			

Division of Health Service Regulation

STATE FORM 6899 03ET11 If continuation sheet 2 of 8

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BOILDING	7. BOILDING.	
		MHL0601227	B. WING		10/26/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
MERANC	AS COTTAGE	6750 SAIN	FPETERS LAN	NE, SUITE 300	
		MATTHEW	S, NC 28105		
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
V 537	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 seand 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.	name. In of MH/DD/SAS may ocumentation at any time. In action and Training all demonstrate competence esting in a training program reducing and eliminating the serventions. In all demonstrate competence esting in a training program ecclusion, physical restraint in a training in an ecclusion in an ecclusion of testing in a training in an ecclusion of testing in a training in an ecclusion of testing in an ecclusion of testing in a training program ecclusion, physical restraint in a training program ecclusion, physical res	V 537		
	service provider plans approved by the Divis to Subparagraph (j)(6) (6) Acceptable shall include, but not of: (A) understandin (B) methods for course; (C) evaluation of (D) documentat (7) Trainers shall annually and demons of seclusion, physical	ion of MH/DD/SAS pursuant			

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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
7.1.12 . 27.11 .			A. BUILDING: _	A. BUILDING:		
		MHL0601227	B. WING		10/2	6/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
MERANCA	AS COTTAGE		T PETERS LAN S, NC 28105	NE, SUITE 300		
(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 CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
V 537	CPR. (9) Trainers shall in teaching the use of least two times with a coach. (10) Trainers shall use of restrictive internationally. (11) Trainers shall instructor training at least the commentation of inititation for at least the commentation of training for at least the commentation of the commentation of training for at least the commentation of the commenta	all be currently trained in all have coached experience f restrictive interventions at a positive review by the all teach a program on the rventions at least once all complete a refresher east every two years. a shall maintain all and refresher instructor ree years. tion shall include: eated in the training and the	V 537			
	requirements as a tra (2) Coaches sh times, the course whi (3) Coaches sh competence by comp train-the-trainer instru (m) Documentation s preparation as for train This Rule is not met Based on record revi	nall meet all preparation iner. nall teach at least three ch is being coached. nall demonstrate oletion of coaching or action. shall be the same iners. as evidenced by: iews and interviews the e that one of one former				

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Division of Health Service Regulation

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _	A. BUILDING:			
		MHL0601227	B. WING		10/	26/2020	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	ΓE, ZIP CODE			
MEDANC	AS COTTAGE	6750 SA	INT PETERS LAN	IE, SUITE 300			
MERANO	AO OOTTAGE	MATTHE	WS, NC 28105				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE / CROSS-REFERENCED 1 DEFICII	ACTION SHOULD BE FO THE APPROPRIATE	(X5) COMPLETE DATE	
V 537	Continued From page	e 4	V 537				
		erforming restraints. The					
	revealed:	of FS#1 personnel record					
	-Hire date 1-7-19 -Separation date	9-16-20					
	-Trainings include: TCI (Therapeutic Crisis Intervention) last completed 8-16-20 Review on 10-20-20 of video of restraint revealed:						
		out of what appeared to be #1 was outside the door.					
		ough the door. Client #1					
	-	S#1 and Client #1's arm's					
		rs FS#1 trying to catch					
		and Client #1 arms were					
	-	ning each other. FS#1					
		office and outside of #1's arms are visible Client					
	_	multiple times. Therapist					
		out of office. FS#1 and					
		it of office. Therapist takes					
		way, FS#1 continues to					
	approach therapist ke	eeps them separated, FS#1					
	leaves the room.						
	Interview on 10-20-20 with Client #1 revealed:						
		t mad at me, I don't oushed me, I pushed her."					
		went back back and forth,					
	pushing each other.	. Work back back and forth,					
		ny eye but it didn't hurt."					
		aggression till she touched					
	me."						
	-This was the firs	st time this had happened					
	and all the other staff						
	-The therapist se						
	-" I didn't stop un	itil she got me away from her.					

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	OLAN OF CORRECTION INTERCATION NUMBERS		ATE SURVEY DMPLETED			
			A. BUILDING:	A. BUILDING:		
		MHL0601227	B. WING		10	0/26/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	E, ZIP CODE		
		6750 SA	INT PETERS LANE	E, SUITE 300		
MERANC	AS COTTAGE	MATTHE	WS, NC 28105			
(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 (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
V 537	Continued From page	e 5	V 537			
	[Therapist] got her aw	vay that's really all."				
	Interview on 10-20-20 revealed: -He was a theragincident, he was now - He heard a conwas walking in the dowas "about to get put -Client #1 comes struggle between FS# -Client #1 was trykicked her, they "lock staff office. -He saw FS#1 ap#1's face, but did not #1's face. -He heard Client me B***h." -"The scuffle conapart. They were engroom." -He and Client # believes he told FS#1 -Client #1 remainat FS#1.	object at the time of the a supervisor. Inmotion in the next room, he bor, FS#1 said the Client #1 down" meaning restrained. Is out of the office and a #1 and Client #1 ensues. If ying to attack FS#1, Client #1 ed up" and went into a small opear to try to grab Client see her hit or grab Client #1 say, "Oh, you want to hit tinued I was trying to break taged, had to pull him out of 1 walked away and he I to leave the cottage. Indeed agitated, he was cursing				
	but Client #1 did not h	• •				
		lent he had "constantly" t her tone of voice, which sive.				
	outside. -She started to p transitioned him insid -Client #1 locked only the supervisors h	ecome upset when they were rocess with him and				

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	F OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		, ,	X3) DATE SURVEY COMPLETED	
		MHL0601227	B. WING		10	/26/2020	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STAT	E, ZIP CODE			
MEDANC	AS COTTAGE	6750 SAIN	NT PETERS LAN	E, SUITE 300			
WIERANG	43 COTTAGE	MATTHEV	VS, NC 28105				
(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 THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE	
V 537	open the office door, opened it, or if Client: - "He (Client #1) attempted to put him it therapist got involved interrupted my restrai. -Client #1 was hit office. I had my hands. -The only time he when Client #1 was trying to the was trying to because he was trying therapist would not all. -She was trying to the was trying therapist would not all. -She thought it we therapist was transition wanted to keep the nucleon to try to attage two male staff and. -She went to get continued to try to attage two male staff and. -She knew that Chad hit him in the face. -Client #1 had off was being restrained, raped, he has said thing. -She went to see incident was over and interrupted her restrail.	me in and she asked him to but she didn't know if he #1 came out on his own. came out attacking me. I in a small child hold. The which was unusual. He nt." tting. He went into the staff is open the entire time. er hands were closed was ying to bite her and she was diffeeding the bite." to take Client #1's shoes g to kick her, but the low her to do that. as important to note that the oning to be a supervisor and umber of restraints assistance but Client #1 ack them so she went and diswapped out with them. Client #1 had said that she is but she had not done that. Item yelled things when he "he has yelled he is being ngs." the therapist after the I told him that he had	V 537				
	hasn't seen video"We tell staff, yo management, if you o don't initiate a restrair	an't safely control a child,					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				DATE SURVEY COMPLETED			
		MHL0601227			10/2	26/2020			
NAME OF F	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6750 SAINT PETERS LANE, SUITE 300								
MERANC	AS COTTAGE		S, NC 28105	4L, 0011L 300					
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE			
V 537	behind and staff pres their side and wrap th balance and move to -All staff are train aggressor, to step ba small child hold is no -Staff are trained defense and back up -If it looks like the they are grabbing the -"The basic princ minimum force."	ses the clients arms close to neir arms around them. They the ground. ned that is the client is the ck, they have to back up, a tinitiated from the front. It to put their hands up in a sestaff is the aggressor, if e client, it is not appropriate. Siple is maximum care and it sounds like she could not	V 537						

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