STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0411101	A. BUILDING: _____ B. WING _____	C 11/06/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
M & S CREEKSIDE	7312 FRIENDSHIP CHURCH ROAD

(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) COMPLE DATE
V 000	V 000 INITIAL COMMENTS A Complaint Survey was completed on November 6, 2020. The complaint was unsubstantiated (intake #N000170215). Deficiencies were cited. This facility is licensed for the following service category: - 10A NCAC 27G .56000: Supervised Living for Adults with Developmental Disabilities			
V 121	V 121 27G .0209 (F) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (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 staff failed to ensure a review of each client' s drug regimen was; reviewed at least		QP contacted pharmacy (Layne family care) and setup for a licensed pharmacy consultant to perform medication review at all facilities on a 6 month cycle. The pharmacy consultant conducted a medication review on 11/11/20 for all facilities. Medication review sheet were completed on each individual resident and were placed in client records. Pharmacy consultant will be back on May 2021 and will follow-up every six months moving forward. The Director/QP will be responsible for making sure medication reviews are completed every six (6) months. DHSR-Mental Health NOV 24 2020 Lic. & Cert. Section	

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	MI-11_0411101	A. BUILDING: _____ B. WING	C 11/06/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
M & S CREEKSIDE	7312 FRIENDSHIP CHURCH ROAD BROWN SUMMIT, NC 27214

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V 121	Continued From page 1	V 121		

physician was informed of the results of the review, for three (client #1, client #2 and former client #3) of three clients surveyed.
The findings are:

Review on 11-2-20 of client #1 ' s facility record revealed:
- admitted 6-2-19
- 70 years old
- diagnosed with:
  - Moderate Intellectual Disability
  - Discoid Lupus
  - Seizure Disorder -controlled by medication
  - Static Encephalopathy
  - Osteopenia
  - Alopecia Creata
- prescribed by her physician on 9-3-20:
  - buspirone hydrochloride, 15 milligrams (mg) one, twice daily
- no documentation of a drug regimen review,

Review on 11-2-20 of client #2 ' s facility record revealed:
- admitted 11-1-11
- 46 years old
- diagnosed with:
  - Moderate Intellectual and developmental disability
  - Prader-Willi Syndrome
  - Unspecified Mental Disorder due to Prader-Willi Syndrome
- prescribed by her physician on 7-23-20:
  - citalopram 40 mg. one, daily
  - alprazolam 0.25 mg. one, twice daily
  - buspirone hydrochloride 5 mg. one, twice daily
- no documentation of a drug regimen review

Review on 11-2-20 and 11-3-20 of former client

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M & S CREEKSIDE	7312 FRIENDSHIP CHURCH ROAD

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V 121	Continued From page 2	V 121		

#3 ' s facility record revealed:
- admitted 7-28-16
- discharged 8-1-20
- 32 years old
- diagnosed with:
  - Bipolar Disorder
  - Intellectual Disability- Profound
  - Attention Deficit-Hyperactivity Disorder
  - Oppositional Defiant Disorder
- prescribed by her physician on 7-17-20:
  - Adderall 20 mg. one, daily
  - Concerta 36 mg. one, daily
- prescribed by her physician on 5-14-20:
  - Klonopin 0.5 mg. one in the morning, two at 4:00 pm
  - quetiapine fumerate 100 mg. one at 2:00 pm, one at 4:00 pm
  - quetiapine fumerate 300 mg. one at bedtime
  - trazadone 50 mg. one at bedtime
- no documentation of a drug regimen review

Interview on 11-5-20 with former client #3 ' s legal guardian revealed:
- former client #3 was on too many drugs
- her primary care physician could not explain why former client #3 was on some of her medications

Interview on 11-4-20 with staff #1 revealed:
- all clients see their doctors every 3 months or more often
- she transported clients to doctor' s appointments
- she was unaware of psychiatric medication reviews

Interview on 11-6-20 with staff # 3 revealed:
- clients usually see a nurse practitioner or

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M & S CREEKSIDE	7312 FRIENDSHIP CHURCH ROAD BROWN SUMMIT, NC 27214

(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 3 - they see their doctors, "at least once every 2 -3 months" - she did not transport or attend doctor ' s appoinments - she did review case management notes regarding doctor' s visits - she did not remember if she had ever seen a psychiatric medication review in the clients' facility record Interview on 11-3-20 and 11-6-20 with the 1 Director/Qualified Professional revealed: - clients see a nurse practitioner for the medication management appointments - there is no Medical Doctor (MD) seen every 6-months for a specific medication review - "We have no form or document for an MD - she had already contacted their pharmacy about the medication reviews - the facility and 2 other sister facilities will be utilizing their pharmacy to conduct the required psychiatric medication reviews - the facility will have their clients ' medications reviewed on Wednesday, November 11, 2020.	V 121		
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,	V 536		

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V 536	Continued From page 4 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 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	V 536		

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V 536	Continued From page 5 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 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.	V 536		

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536	Continued From page 6 (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 (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		

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V 536	Continued From page 7	V 536		

This Rule is not met as evidenced by:
Based on interview and record review, the facility failed to maintain documentation of initial or refresher training on Alternatives to Restrictive Interventions for two (staff #1 and staff #2) of six hire staff surveyed.
The findings are:

Review on 11-2-20 of staff #1 ' s personnel record revealed:
- hired 7-7-16
- position, direct care staff
- is usually scheduled to work weekends
- training on Alternative to Restrictive Interventions expired 10-27-20

Review on 11-2-20 of staff #2 ' s personnel record revealed:
– d 9-20-19
- position, direct care staff
- is usually scheduled to work third shifts
– training on Alternatives to Restrictive Interventions expired 10-27-20

Interview with the Director/Qualified Professional on 11-2-20 and 11-6-20 revealed:
- she is responsible for making sure all staff are properly trained
– is aware some staffs ' training on Alternatives to Restrictive Interventions has expired
- the needed training has already been

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V 536	Continued From page 8 scheduled 1 - it was difficult to schedule training due to the recent Co-Vid 19 Pandemic - in the future a chart will be utilized to ensure trainings are scheduled prior to the date they expire	V 536	QP will create an excel spreadsheet by 12/1/20 to help ensure trainings are scheduled prior to the date they expire. QP will be responsible for this spreadsheet and this will be reviewed on a monthly basis or as needed. Staff #1 and Staff #2 will complete training on 11/20/2020.	
V 537	27E .0108 Client Rights - Training in Sec Rest & ITO 10A NCAC 27E .0108 TRAINING IN SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT (a) Seclusion, physical restraint and isolation time-out may be employed only by staff who have been trained and have demonstrated competence in the proper use of and alternatives to these procedures. Facilities shall ensure that staff authorized to employ and terminate these procedures are retrained and have demonstrated competence at least annually. (b) Prior to providing direct care to people with disabilities whose treatment/habilitation plan includes restrictive interventions, staff including service providers, employees, students or volunteers shall complete training in the use of seclusion, physical restraint and isolation time-out and shall not use these interventions until the training is completed and competence is demonstrated. (c) A pre-requisite for taking this training is demonstrating competence by completion of training in preventing, reducing and eliminating the need for restrictive interventions. (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	V 537		

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V 537	Continued From page 91 V 537 course. (e) Formal refresher training must be completed by each service provider periodically (minimum annually). (f) Content of the training that the service provider plans to employ must be approved by the Division of MH/DD/SAS pursuant to Paragraph (g) of this Rule. (g) Acceptable training programs shall include, but are not limited to, presentation of: (1) refresher information on alternatives to the use of restrictive interventions; (2) guidelines on when to intervene (understanding imminent danger to self and others); (3) emphasis on safety and respect for the rights and dignity of all persons involved (using concepts of least restrictive interventions and incremental steps in an intervention); (4) strategies for the safe implementation of restrictive interventions; (5) the use of emergency safety interventions which include continuous assessment and monitoring of the physical and psychological well-being of the client and the safe [illegible] 1 [illegible] (6) prohibited procedures; (7) debriefing strategies, including their importance and purpose; and (8) documentation methods/procedures. (h) Service providers shall maintain documentation of [illegible] 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.			

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V 537	Continued From page 10	V 537		

(2) The Division of MH/DD/SAS may review/request this documentation at any time.
(i) Instructor Qualification 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 100% on testing in a training program teaching the use of seclusion, physical restraint and isolation time-out.
(3) Trainers shall demonstrate competence by scoring a passing grade on testing in an instructor training program.
(4) 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.
(5) 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 (j)(6) of this Rule.
(6) Acceptable instructor training programs shall include, but not be limited to, presentation of:
(A) understanding the adult learner;
(B) methods for teaching content of the course;
(C) evaluation of trainee performance; and
(D) documentation procedures.
(7) Trainers shall be retrained at least annually and demonstrate competence in the use of seclusion, physical restraint and isolation time-out, as specified in Paragraph (a) of this Rule.
(8) Trainers shall be currently trained in

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V 537	Continued From page 11 CPR. (9) Trainers shall have coached experience in teaching the use of restrictive interventions at least two times with a positive review by the coach. (10) Trainers shall teach a program on the use of restrictive interventions at least once annually. (11) Trainers shall complete a refresher instructor training at least every two years. (k) Service providers shall maintain documentation of initial and refresher instructor training for at least three years. (1) Documentation shall include: I (A) who participated in the training and the outcome (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. (l) 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. (m) Documentation shall be the same preparation as for trainers. This Rule is not met as evidenced by: Based on interview and record review, the facility failed to maintain documentation of initial or refresher training on Seclusion, Physical Restraint and Isolation Time-Out, for two (staff #1	V 537		

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537	Continued From page 12 and staff #2) of six staff surveyed. The findings are: Review on 11-2-20 of staff #1 ' s personnel record revealed: - hired 7-7-16 - position, direct care staff - is usually scheduled to work weekends - training on Seclusion, Physical Restraint and Isolation Time-Out expired 10-27-20 Review on 11-2-20 of staff #2 ' s personnel record revealed: - hired 9-20-19 - position, direct care staff - is usually scheduled to work third shifts - training on Seclusion, Physical Restraint and Isolation Time-Out expired 10-27-20 Interview with the Director/Qualified Professional on 11-2-20 and 11-6-20 revealed: - she is responsible for making sure all staff are properly trained - is aware some staffs ' training on Seclusion, Physical Restraint and Isolation Time-Out has expired - the needed training has already been scheduled - it was difficult to schedule training due to the recent Co-Vid 19 Pandemic - in the future a chart will be utilized to ensure trainings are scheduled prior to the date they expire	V 537	QP will create an excel spreadsheet by 12/1/20 to help ensure trainings are scheduled prior to the date they expire. QP will be responsible for this spreadsheet and this will be reviewed on a monthly basis or as needed. Staff #1 and Staff #2 will complete training on 11/20/2020.	

NC DEPARTMENT OF
HEALTH AND
HUMAN SERVICES

ROY COOPER • Governor
MANDY COHEN, MD, MPH • Secretary
MARK PAYNE • Director, Division of Health Service Regulation

DHSR-Mental Health
NOV 24 2020
Lic. & Cert. Section

November 13, 2020

April Evans
M & S Supervised Living, LLC
7312 Friendship Church Road
Browns Summit, NC. 27214

Re: Complaint Survey completed November 6, 2020
M & S Creekside, 7312 Friendship Church Rd. Brown Summit, NC. 27214
MHL # 041-1101
E-mail Address: mssupervisedliving@yahoo.com
Intake #NC00170215

Dear Ms. Evans:

Thank you for the cooperation and courtesy extended during the Complaint Survey completed November 6, 2020. The complaint was unsubstantiated.

Enclosed you will find all deficiencies cited listed on the Statement of Deficiencies Form. The purpose of the Statement of Deficiencies is to provide you with specific details of the practice that does not comply with state regulations. You must develop one Plan of Correction that addresses each deficiency listed on the State Form, and return it to our office within ten days of receipt of this letter. Below you will find details of the type of deficiencies found, the time frames for compliance plus what to include in the Plan of Correction.

Type of Deficiencies Found

- All tags cited are standard level deficiencies.

Time Frames for Compliance

- Standard level deficiencies must be ***corrected*** within 60 days from the exit of the survey, which is January 5, 2021.