PRINTED: 11/12/2020 FORM APPROVED Division of Health Service Regulation STATEMENT OF (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY DEFICIENCIES AND PLAN IDENTIFICATION NUMBER: COMPLETED OF CORRECTION A. BUILDING: _ C B. WING MHL0411101 11/06/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE M & S CREEKSIDE 7312 FRIENDSHIP CHURCH X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION PRFFIX (X5)(EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX COMPLÉ TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE DEFICIENCY) V 000 INITIAL COMMENTS V 000 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 QP contacted pharmacy (Layne family care) Living for Adults with Developmental and setup for a licensed pharmacy consultant Disabilities to perform medication review at all facilities on V₁₂₁ a 6 month cycle. The pharmacy consultant V 121 27G .0209 (F) Medication Requirements conducted a medication review on 11/11/20 10A NCAC 27G .0209 for all facilities. Medication review sheet were MEDICATION REQUIREMENTS completed on each individual resident and (f) Medication review: were placed in client records. Pharmacy (1) If the client receives psychotropic drugs, the governing body or operator shall be consultant will be back on May 2021 and will responsible for obtaining a review of each follow-up every six months moving forward client's drug regimen at least every six The Director/QP will be responsible for making months. The review shall be to be performed sure medication reviews are completed every by a pharmacist or physician. The on-site manager shall assure that the client's six (6) months. 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. DHSR-Mental Health MOV 2 4 2020 Lic. & Cert. Section This Rule is not met as evidenced by: Based on interview and record review, the

Division of Health Service Regulation LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATUR (X6) DATE STATEFORM

facility staff failed to ensure a review of each client's drug regimen was; reviewed at least

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: C B. WING MI-11_0411101 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 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5)PREFIX COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE DEFICIENCY) 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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Division	of Health Service R	egulation	FORM APPROVED			
STATEM	ENT OF NCIES AND PLAN OF	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY IPLETED
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V 121	Continued From		V 121			
	- Attention I - Opposition - prescribed by - Adderall 2 - Concerta 3 - prescribed by - Klonopin 0 two at 4:00 pm - quetiapine 2:00 pm, one at 4:00 - quetiapine bedtime - trazadone - no documentat Interview on 11-5-20 guardian revealed: - former client #3 - her primary ca why former client #3 medications Interview on 11-4-20 - all clients see to or more often - she transported appointments - she was unawareviews	h: sorder ld Disability- Profound Deficit-Hyperactivity Disorder hal Defiant Disorder her physician on 7-17-20: 0 mg. one, daily 36 mg. one, daily her physician on 5-14-20: 0.5 mg. one in the morning, fumerate 100 mg. one at 0 pm fumerate 300 mg. one at 50 mg. one at bedtime ion of a drug regimen review with former client #3 's legal was on too many drugs re physician could not explain was on some of her with staff #1 revealed: their doctors every 3 months clients to doctor's are of psychiatric medication				
1		with staff # 3 revealed: see a nurse practitioner or				

Division of Health Service Regulation

	ENT OF DEFICIENCIES IN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDIN	E CONSTRUCTION G:	(X3) DATE SURVEY COMPLETED
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V 12	1 Continued From pag	ne 3	V 121	DEEICIENICY	DATE
	-3 months" - she did not tra appoinments - she did review regarding doctor' s vi - she did not rer	doctors, "at least once every 2 insport or attend doctor's vase management notes isits member if she had ever seen tion review in the clients'			
	medication managem - there is no Med 6-months for a specifi - "We have no fo - she had alread about the medication	ofessional revealed: urse practitioner for the nent appointments dical Doctor (MD) seen every ic medication review orm or document for an MD y contacted their pharmacy			
V 536	utilizing their pharmac psychiatric medicatior - the facility will h medications reviewed 11, 2020.	by to conduct the required neviews lave their clients ' on Wednesday, November	V 536		
	Int. 10A NCAC 27E .0107 ALTERNATIVES TO F INTERVENTIONS (a) Facilities shall im practices that emphasi to restrictive interventic	plement policies and ize the use of alternatives ons.		(

Division of Health Service Regulation FORM APPROVED STATEMENT OF (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION DEFICIENCIES AND PLAN (X3) DATE SURVEY **IDENTIFICATION NUMBER:** OF CORRECTION A. BUILDING: COMPLETED MHL0411101 B. WING 11/06/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP M & S CREEKSIDE 7312 FRIENDSHIP CHURCH (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) COMPLE TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) V 536 Continued From page 4 V 536 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. Provider agencies shall establish training based on state competencies, monitor for internal compliance and demonstrate they acted on data gathered. 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). 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. Staff shall demonstrate competence in the following core areas: knowledge and understanding of (1)the people being served; recognizing and interpreting (2)human behavior; recognizing the effect of internal and external stressors that may affect people with disabilities: strategies for building positive relationships with persons with disabilities: recognizing cultural, environmental and organizational factors that may affect

people with disabilities;

recognizing the importance of

Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING: COMPLETED B. WING MHL0411101 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 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE DEFICIENCY) V 536 Continued From page 5 V 536 decisions about their life; (7)skills in assessing individual risk for escalating behavior; 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: who participated in the training and the (A) outcomes (pass/fail); when and where they attended; and (B) (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: Trainers shall demonstrate competence by scoring 100% on testing in a training program aimed at preventing, reducing and eliminating the need for restrictive interventions. 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. The content of the instructor training the (4)service provider plans to employ shall be approved by the Division of MH/DD/SAS pursuant

to Subparagraph (i)(5) of this Rule.

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PRINTED: 11/12/2020 FORM APPROVED Division of Health Service Regulation STATEMENT OF (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY DEFICIENCIES AND PLAN OF **IDENTIFICATION NUMBER:** A. BUILDING: COMPLETED CORRECTION C MHL0411101 B. WING 11/06/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP M & S CREEKSIDE 7312 FRIENDSHIP CHURCH 4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ₹EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5)**PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) 536 Continued From page 6 V 536 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. 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. Trainers shall teach a training program (⁷) 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); when and where attended; and (B) (C) instructor's name. (2)The Division of MH/DD/SAS may request and review this documentation any time. (k) Qualifications of Coaches:

for trainers.

(1)

(2)

requirements as a trainer.

train-the-trainer instruction.

the course which is being coached.

Coaches shall meet all preparation

Coaches shall demonstrate competence by completion of coaching or

(I) Documentation shall be the same preparation as

Coaches shall teach at least three times

	ealth Service Reg				TORMATTROVE	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE IDENTIFICATION NUMBER: A. BUILDING:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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Inter Inter Alte	ed to maintain docuesher training on Arventions for two (staff surveyed, findings are: iew on 11-2-20 of staled: - hired 7-7-16 - position, direct color is usually scheduled training on Altern twentions expired to the surveyed is usually scheduled; - d 9-20-19 - position, direct color is usually scheduled; - training on Altern twentions expired to the surveyed to	and record review, the facility amentation of initial or alternatives to Restrictive staff #1 and staff #2) of six staff #1 's personnel record are staff alled to work weekends native to Restrictive 10-27-20 staff #2 's personnel record are staff alled to work third shifts atives to Restrictive 0-27-20 rector/Qualified Professional 20 revealed: ole for making sure all staff				

PRINTED: 11/12/2020 FORM APPROVED Division of Health Service Regulation STATEMENT OF (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY DEFICIENCIES AND PLAN IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ OF CORRECTION C MHL0411101 B. WING 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 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION PREFIX 1 (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRFFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLÉTE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) V 536 I1 Continued From page 8 QP will create an excel spreadsheet by V 536 12/1/20 to help ensure trainings are scheduled scheduled prior to the date they expire. QP will be 1 - it was difficult to schedule training responsible for this spreadsheet and this will due to recent Co-Vid 19 Pandemic be reviewed on a monthly basis or as needed. - in the future a chart will be utilized to Staff #1 and Staff #2 will complete training on ensure trainings are scheduled prior to the date 11/20/2020. they expire V 537 27E .0108 Client Rights - Training in Sec Rest & V 537 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

methods to determine passing or failing the sion of Health Service Regulation

training in preventing, reducing and eliminating

(d) The training shall be competency-based, include measurable learning objectives,

measurable testing (written and by observation of behavior) on those objectives and measurable

the need for restrictive interventions

iv ion of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: COMPLETED B. WING MEIL0411101 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** (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRFFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) Continued From page 91 V 537 V 537 1 (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); emphasis on safety and respect for the (3)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; 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 1 1 diado (6)prohibited procedures; 11 debriefing strategies, including their importance and purpose; and documentation methods/procedures. (h) Service providers shall maintain downer tetrnof relative feature from t attestneevees Documentation shall include: (1) (A) who participated in the training and the outcomes (pass/fail); when and where they attended; and (B) (C) instructor's name.

Division of Health Service Re	egulation			FORIVI APPROVED
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(2) The Division	on of MH/DD/CAC			
review/request this	on of MH/DD/SAS may			
(i) Instructor Qualific	documentation at any time.			
(i) Instructor Qualific Requirements:	ation and Training			
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by scoring 100% on	nall demonstrate competence			
aimed at proventing	testing in a training program			
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(2) Trainers sh	nall demonstrate competence			
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and isolation time-ou	seclusion, physical restraint			
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	nall demonstrate competence			
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objectives, measurai	ole testing (written and by			
poservation of benav	rior) on those objectives and			
	to determine passing or			
failing the course.	Cathara Carlo and a second	1		
(5) The conten	t of the instructor training the			
service provider plan	s to employ shall be			
to Subparagraph (i)/(i	sion of MH/DD/SAS pursuant			
to Subparagraph (j) (6)				
(6) Acceptable	instructor training programs			
shall include, but not be limited to, presentation of:				
	ling the adult learner;			
	teaching content of the			
course;	todoning content of the			
	of trainee performance; and			
	tion procedures.			
	all be retrained at least			
annually and demon	strate competence in the			
use of seclusion, ph	vsical restraint and			
isolation time-out	s specified in Paragraph (a)			
of this Rule.	s specified in Paragraph (a)			
	all be currently trained in			4
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		NT OF DEFICIENCIES NOF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	I (A)	experience in teach interventions at least review by the coach (10) Trainers: use of restrictive interannually. (11) Trainers instructor training at Service providers st documentation of in instructor training for (1) Document who pare outcome (pass/fail); (B) when and view (C) instructor's (2) The Division review/request this direction of City Coaches street (2) Coaches street (3) Coaches street (3) Coaches street (3) Coaches street (3) Coaches street (4) Documentation street (5) Documentation as for train-the-trainer instruction (5) Documentation as for train-this Rule is not met as Based on interview ar	shall have coached ing the use of restrictive st two times with a positive in shall teach a program on the erventions at least once shall complete a refresher it least every two years. (k) shall maintain itial and refresher it least three years. It least three years is ation shall include: articipated in the training and the where they attended; and name. It is not of MH/DD/SAS may occumentation at any time, oaches: shall meet all preparation shall teach at least three ch is being coached. Shall demonstrate eletion of coaching or action. The shall be the same iners.	V 537			
		refresher training on S	umentation of initial or Seclusion, Physical n Time-Out, for two (staff #1			•	

DIVISIO	on of Health Service Re	egulation			. 0
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537	Review on 11-2-20 or revealed: - hired 7-7-16 - position, direct - is usually sche training on Sec and Isolation Time-C Review on 11-2-20 or revealed: - hired 9-20-19 - position, direct - is usually schect - training on Sec and Isolation Time-O Interview with the Dir on 11-2-20 and 11-6 she is responsilare properly trained - is aware some: Seclusion, Physical F Time-Out has expired - the needed train scheduled - it was difficult to recent Co-Vid 19 Pan - in the future a c	aff surveyed. The findings are: of staff #1's personnel record care staff duled to work weekends clusion, Physical Restraint out expired 10-27-20 of staff #2's personnel record care staff duled to work third shifts lusion, Physical Restraint out expired 10-27-20 rector/Qualified Professional -20 revealed: ble for making sure all staff staffs' training on Restraint and Isolation d ning has already been schedule training due to the	V 537	QP will create an excel spr 12/1/20 to help ensure train prior to the date they expire responsible for this spreads be reviewed on a monthly the Staff #1 and Staff #2 will consider the staff #2 will will will be staff #2 will consider the staff #2 will will be staff #2 will will be staff #2 will will will be staff #2 will will will be staff #2 will will be staff #2 will be sta	nings are scheduled e. QP will be sheet and this will basis or as needed.



ROY COOPER • Governor

MANDY COHEN, MD, MPH • Secretary

MARK PAYNE • Director, Division of Health Service Regulation

DHSR-Mental Health

MOV 2 4 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.

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES • DIVISION OF HEALTH SERVICE REGULATION