PRINTED: 12/22/2020
FORM APPROVED
Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL040006	A. BUILDING: _____ B. WING _____	12/15/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOPEWELL	292 DOGWOOD LANE SNOW HILL, NC 28580

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V 000	INITIAL COMMENTS A complaint and follow up survey was completed on December 15, 2020. The complaints were unsubstantiated (intake # NC00170077 and NC00171336). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities.	V 000	V114 Our members having knowledge, understanding, and abilities to identify safety issues, and respond appropriately, is paramount to their health and safety. In order to immediately correct this deficiency, the following procedure has been implemented immediately - At the beginning of the quarter, the Director of Operations will publish a drill schedule, with various scenarios specific to the Hopewell home. The schedules will identify both the date and time that the drill is to be conducted in the home - The Director of Operations will provide a copy of the schedule to the Group Home Leader of the house, as well as the Service Coordinator/QP who oversees clinical operations in the Hopewell House. Furthermore, a calendar invite will be sent to the House's e-mail account so that a notification will be displayed on the laptop on the date when a drill is scheduled to be conducted. - All drills on the schedule will be	1/1/21
V 114	27G .0207 Emergency Plans and Supplies 10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES (a) A written fire plan for each facility and 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. This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to hold fire and disaster drills at least quarterly for each shift. The findings are: Review on 11/30/20 of facility records from November 2019 through November 2020 revealed:	V 114		

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V 114	Continued From page 1 Fire Drills: -Feb 2020- Apr- 2020 - No first and 3rd shift documented. -May 2020- July 2020- No 3rd shift documented. -Aug 2020- Oct 2020- No third shift documented. -November 2020 - No first, second and third shift documented. Disaster Drills: -November 2019- Jan 2020- No first shift documented. -Feb 2020- Apr- 2020 - No third shift documented. -May 2020- July 2020- No second and third shift documented. -Aug 2020- Oct 2020- No second and third shift documented. -November 2020- No first, second and third shift documented. During interview on 12/7/20 the Director of Operations stated: -A fire and disaster drill schedule is posted at the facility quarterly. -He understood fire and disaster drills were required for each shift quarterly. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 114	scheduled for the first two months in the quarter. At the conclusion of the second month, the Director of Operations will conduct a review of the drills that have been turned in. If drills were not completed per the schedule, a new revised schedule will be developed and published to the house to ensure that drills are conducted to meet this requirement The Director of Operations will be responsible for monitoring this procedure and ensuring that all drills are conducted per this Rule. The DoO will monitor this quarterly.	
V 118	27G .0209 (C) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS	V 118		

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V 118	Continued From page 2 (c) Medication administration: (1) Prescription or non-prescription drugs shall only be administered to a client on the written order of a person authorized by law to prescribe drugs. (2) Medications shall be self-administered by clients only when authorized in writing by the client's physician. (3) Medications, including injections, shall be administered only by licensed persons, or by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer medications. (4) A Medication Administration Record (MAR) of all drugs administered to each client must be kept current. Medications administered shall be recorded immediately after administration. The MAR is to include the following: (A) client's name; (B) name, strength, and quantity of the drug; (C) instructions for administering the drug; (D) date and time the drug is administered; and (E) name or initials of person administering the drug. (5) Client requests for medication changes or checks shall be recorded and kept with the MAR file followed up by appointment or consultation with a physician. This Rule is not met as evidenced by: Based on record reviews, observations, and interviews the facility failed to administer medications as ordered by a Physician for 3 of 3 audited clients (#3, #4, and #5). The findings are:	V 118	V118 Ensuring that member's receive their medication as ordered by a licensed physician is paramount to the health and safety of the members served by Ambleside, and it is the highest priority of Ambleside to ensure that this is occurring and documented appropriately. In order to ensure that Hopewell staff members are fully competent in this area, all Hopewell staff will be re-inserviced by Ambleside, Inc.'s Medical Coordinator no later than 1/10/2020. All staff will be re-trained in the following areas: - Ambleside, Inc. Med Admin P & P - Procedure to document on the e-MAR system - Procedure to document on the Back-up Paper MAR system - Utilization of "Exceptions" in the E-MAR system - Level 1 Incident Report procedure, calling the pharmacy, and documenting appropriately. In addition to the re-training of staff, Ambleside has contacted the e-MAR	1/14/21

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V 118	Continued From page 3 Review on 11/18/20 and 12/09/20 of client #3's record revealed: - 27 year old male admitted 3/05/12. - Diagnoses included Autism, Mood Disorder, severe Intellectual/Developmental Disability, Intermittent Explosive Disorder, Schizoaffective Disorder, Seizure Disorder. - Physician's orders signed 8/28/20 included Vitamin D3 2000 international units (iu) 1 tablet daily, buspirone (can treat anxiety) 15 mg 1 tablet twice daily, docusate sodium (can treat constipation) 100 mg 1 capsule twice daily, Haldol (anti-psychotic) 2 mg 1 tablet every morning, and signed 9/25/20 for zinc 5 mg 1 tablet daily. Review on 12/07/20 and 12/08/20 of client #3's MARs for October - December 2020 revealed: - Transcribed entries for medications as ordered. - Circled staff initials with "Out of Facility" listed under "Exceptions" for: 10/14/20 8:00 am buspirone and 10/02/20, 10/08/20, 10/09/20, 10/14/20 - 10/18/20, and 10/29/20 haloperidol 2 mg. - Other 8:00 am medications documented as administered on those dates. - Blanks with no explanations for the omissions for 11/04/20 8:00 am buspirone, docusate, haloperidol, vitamin D3, and zinc; and circled staff initials with "Out of Facility" listed under "Exceptions" for haloperidol 11/06/20. - Blanks for 12/07/20 8:00 am buspirone, docusate, vitamin D3, and zinc (review of December 2020 MAR on 12/07/20 at approximately 10:30 am). Review on 12/07/20 and 12/08/20 of client #4's record revealed: - 41 year old male. - Diagnoses included Intermittent Explosive	V 118	Ambleside has reached out to the software administrator of the e-MAR system and requested that the "out of facility" require staff to make a comment. We believe that this will ensure that additional context is added when staff utilize this "exemption" in the system. Additionally, we have asked for a new exception be put in place labeled "Med Not Available." This exemption will also require a comment be entered by staff to show that effort was made to locate the medication if it was not initially identified as present by the staff. Both of these changes to the e-MAR system will be flagged to the medical coordinator who will be able to follow-up with the staff member working that shift to identify whether or not the medication was passed to the individual identified. We feel as though both of these measures will increase our ability to monitor med passes, and identify when and if a member did not receive their medication per doctor's orders, and verify whether or not the staff followed	

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V 118	Continued From page 4 Disorder, moderate Intellectual/Developmental Disability, Seizure Disorder, Fragile X Syndrome. - Physician's orders signed 8/24/20 included benztropine 1 mg twice daily, levetiracetam (anti-convulsant) 1000 mg 1 tablet every morning, haloperidol 20 mg 1/2 tablet (10 mg) three times daily in the morning, at noon and every evening, omeprazole (can treat gastroesophageal reflux disease and heart burn) 20 mg 1 capsule daily, vitamin D2 2000 iu 1 capsule daily, divalproex 500 mg 2 tablets in the morning, Dentagel 1.1% gel scrub teeth, swish with mouthwash for 60 seconds at bedtime. Review on 12/07/20 and 12/08/20 of client #4's MARs for October - December 2020 revealed: - Transcribed entries for medications as ordered. - Blanks with no explanations for the omissions for 11/04/20 8:00 am benztropine, divalproex, haloperidol, levetiracetam, omeprazole and vitamin D2; and 11/10/20 and 11/23/20 12:00 noon haloperidol and 11/01/20 8:00 pm benztropine, Dentagel, haloperidol, and levetiracetam. - Staff #6's initials indicated the following medications were administered: 12/07/20 8:00 am benztropine, divalproex, haloperidol, levetiracetam, omeprazole, and vitamin D2. Review on 11/17/20 of client #5's record revealed: - 30 year old male admitted 10/02/15. - Diagnoses included Bipolar Disorder, Intermittent Explosive Disorder, Autism, Attention Deficit Hyperactivity Disorder, Anxiety, Allergic Rhinitis, Periodontal Disease, Constipation. - Physician's orders signed 8/24/20 for benztropine 2 mg 1 tablet twice daily, chlorhexidine 0.12% rinse (can treat gingivitis) swish and spit 10 milliliters by mouth twice daily, chlorpromazine (antipsychotic) 200 mg 1 tablet	V 118	Ambleside's incident reporting protocols. Finally, Ambleside will implement mandatory initialling of the Paper MARs during med passes at Hopewell effective 1/10/2021 (to add in a buffer for on-site training). This will require that Ambleside staff members identify med passes on both the E-MAR system, and the backup paper copies present in the home in the event of syncing or general systems errors. This will provide us with a secondary verification system to ensure that the med was given. In order to monitor this program, the Ambleside Medical Coordinator will monitor the E-MAR dashboard, daily (Monday - Friday), and will follow-up with any medication issues identified in the home with the staff member who was on-shift at the time. The Medical Coordinator will also hold the re-trainings for all Hopewell staff members. Finally, the Medical Coordiantor will follow-up	

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V 118	Continued From page 5 twice daily in the morning and at noon, divalproex 500 mg 3 tablets (1500 mg) every morning, fluoxetine (can treat depression and obsessive compulsive disorder) 20 mg 1 tablet every morning, Linzess (can treat chronic constipation) 145 micrograms (mcg) 1 tablet daily, loratadine (antihistamine) 10 mg 1 tablet daily, omeprazole 20 mg 1 capsule daily, risperidone (antipsychotic) 4 mg 1 tablet twice daily, Trazodone (antidepressant) 100 mg 1 tablet at bedtime; and signed 9/08/20 for clonazepam (can treat seizure disorder, panic disorder, and anxiety) 0.5 mg 1 tablet in the morning, 2 tablets at 6 pm. Review on 12/07/20 and 12/08/20 of client #5's MARs for October - December 2020 revealed: - Transcribed entries for medications as ordered. - Blanks with no explanation for the omissions for 11/01/20 8:00 pm benztropine, chlorhexidine, risperidone, trazodone; 11/04/20 8:00 am benztropine, chlorhexidine, chlorpromazine, clonazepam, divalproex, fluoxetine, Linzess, loratadine, omeprazole, and risperidone; 11/04/20 8:00 pm benztropine, chlorhexidine, risperidone, trazodone; 11/10/20 12:00 noon chlorpromazine. - Staff initials indicated the following medications were administered: 11/04/20 12:00 noon chlorpromazine, 6:00 pm clonazepam. - Staff #6's initials indicated the following medications were administered: 12/07/10 8:00 am benztropine, chlorhexidine, chlorpromazine, clonazepam, divalproex, fluoxetine, Linzess, omeprazole, risperidone. Review on 12/11/20 of an email from the Chief Clinical Officer revealed client #5 "was hospitalized 11/04 - 11/09/2020." During interview on 12/07/20 at approximately	V 118	on any instances of missed med passes, and will ensure that staff followed Ambleside's incident reporting procedures, and called the pharmacy as dictated in that procedure.	

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V 118	Continued From page 6 9:30 am staff #6 stated the "starters" (staff #2 and staff #4) were supposed to administer 8:00 am medications; she had arrived late and did not administer medications. The Medical Coordinator said she was monitoring the electronic MARs and she could not see that clients #3, #4, and #5 received their 8:00 am medications prior to leaving the facility that day. The clients told her they took their morning medications. Clients #3, #4, and #5 were in the community with their support staff. During interview on 12/10/20 the Chief Clinical Officer stated: - MARs were electronic. - "Out of facility" on the MAR could mean either the client was out of the facility, "like at a doctor's appointment" or the medication was not available for administration. - MARs were to be monitored daily by the Medical Coordinator. - The Medical Coordinator position was in transition in November and early December, "several people were quarantined" during that period of time and she was on vacation so she did "not know what was going on during that time." During interviews on 12/07/20 and 12/15/20 the Director of Operations stated: - Staff did not administer 8:00 am medications for clients 3, #4, and #5 on 12/07/20. - Staff #2 and staff #4 got their "wires crossed" and there was a miscommunication about 8:00 am medication administration; they each thought the other had given medications. - He did not understand why staff #6 initialed the MARs for clients #4 and #5. - He was not sure why facility staff was having issues with medication administration and	V 118		

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V 118	Continued From page 7 documenting medication administration. - He was going to schedule a team meeting to discuss the issues cited and would make sure the deficiency was corrected. Due to the failure to accurately document medication administration it could not be determined if clients received their medications as ordered by the Physician. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 118		
V 123	27G .0209 (H) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (h) Medication errors. Drug administration errors and significant adverse drug reactions shall be reported immediately to a physician or pharmacist. An entry of the drug administered and the drug reaction shall be properly recorded in the drug record. A client's refusal of a drug shall be charted. . This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to notify the Pharmacist or Physician of medication errors affecting 3 of 3 audited clients (#3, #4, and #5). The findings are: See tag V118 for specific information.	V 123	V123 Please see plan of correction steps identified in above Tag Corrective Measures (V118)	1/14/21

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V 123	Continued From page 8 Review on 12/07/20 and 12/08/20 of client #3's MARs for October - December 2020 revealed: - 11 instances of medications not being available for administration ("out of facility"), and 12 instances of medication administration not documented with no explanation for the omissions. Review on 12/07/20 and 12/08/20 of client #4's MARs for October - December 2020 revealed: - 14 instances of medication administration not documented with no explanation for the omissions. Review on 12/07/20 and 12/08/20 of client #5's MARs for October - December 2020 revealed: - 19 instances of medication administration not documented with no explanation for the omissions. Review on 12/11/20 of documentation provided by the Licensee revealed no evidence a physician or pharmacist was notified of medications missed October - November 2020 for clients #3, #4, and #5. During interview on 12/07/20 staff #6 stated clients #3, #4, and #5 did not receive their 8:00 am medications prior to leaving the facility that day. During interview on 12/10/20 the Chief Clinical Officer stated: - MARs were electronic. - "Out of facility" on the MAR could mean either the client was out of the facility, "like at a doctor's appointment" or the medication was not available for administration. - She was not sure if the Pharmacist or Physician had been notified of missed medications.	V 123		

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V 123	Continued From page 9 - MARs were to be monitored daily by the Medical Coordinator. - The Medical Coordinator position was in transition in November and early December, "several people were quarantined" during that period of time and she was on vacation so she did "not know what was going on during that time." During interviews on 12/07/20 and 12/15/20 the Director of Operations stated: - Staff did not administer 8:00 am medications to clients #3, #4, or #5 on 12/07/20, despite the administration being documented for clients #4 and #5. - The pharmacy had been notified and the facility had received instructions about how to proceed with medication administration. - He understood the requirement for the Pharmacist or Physician to be notified of medication errors. - There was no excuse for missed medications.	V 123		
V 318	13O .0102 HCPR - 24 Hour Reporting 10A NCAC 13O .0102 INVESTIGATING AND REPORTING HEALTH CARE PERSONNEL The reporting by health care facilities to the Department of all allegations against health care personnel as defined in G.S. 131E-256 (a)(1), including injuries of unknown source, shall be done within 24 hours of the health care facility becoming aware of the allegation. The results of the health care facility's investigation shall be submitted to the Department in accordance with G.S. 131E-256(g).	V 318	V318 Reporting a suspected incident of abuse/neglect/or exploitation is an Ambleside, Inc. written policy, and all Clinical staff members are trained on this policy at their time of hire. In this instance, the Service Coordiantor/QP who was initially informed of the suspected abuse for the Hopewell member did not notify her supervisor, nor complete the HCPR report per agency	1/14/21

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V 318	Continued From page 10 This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to notify HCPR of an allegation of abuse within 24 hours of learning of the allegation. The findings are: Review on 11/13/20 of the North Carolina Incident Response Improvement System (IRIS) revealed: - A Level III incident report was completed by the Director of Operations on 9/25/20 for an allegation of possible client abuse that occurred 9/22/20. - "Incident Comments . . . Organization Advocacy Title HCPR Report & follow up info needed Date 9/25/20 . . . Please complete the HCPR Report and provide additional information . . . " - HCPR was notified of the allegation of abuse on 9/25/20 by the Director of Operations. Review on 11/13/20 of the "Investigation Report September 22, 2020"" completed by the Licensee revealed: - ". . . Hopewell staff, [former staff #1] on September 22, 2020, reached out to her Clinical Supervisor [former Service Coordinator/Qualified Professional (SC/QP)2], QP, stating that she had witnessed bruising on a member's arms that she had not seen while conducting body checks two day's prior. . . . On September 23, Chief Clinical Officer [Chief Clinical Officer] was notified by the Service Coordinator/QP [SC/QP #1] that staff had called [former SC/QP2] and reported bruising on member [client #3]. [Director of Operations] reported to the house to follow-up with staff regarding the behavioral incident and noted the	V 318	procedure. As soon as the Chief Clinical Officer and Director of Operations was notified of the bruising on the member, the HCPR report was immediately submitted. The Service Coordinator/QP who violated this policy is no longer employed by Ambleside, Inc. Ensuring that our current Service Coordinators/QPs are aware of this policy and the steps they must take if there is a suspected incident of abuse is paramount in order to ensure that this deficiency does not occur again. For this reason, the Service Coordinators/QPs will be re-trained on this policy and procedure by the Director of Operations. The documentation of re-training will be stored in the Service Coordinator/QPs personnel file.	

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V 318	Continued From page 11 bruising. Because of the bruising, and the unknown source of the bruising, an internal investigation was immediately launched in an attempt to discover if an instance of abuse had occurred . . . on September 22, 2020. . . " - ". . . September 24, 2020 . . . [Director of Operations] completed IRIS Report, including HCRP 24-hour report, and submitted the report with current information. . . " During interview on 12/10/20 the Director of Operations stated he understood the requirement for allegations of abuse to be reported to HCPR within 24 hours of learning of the allegation. He understood providers should complete internal investigations of allegations against health care personnel and report the results within five working days of the initial report.	V 318		
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	V 537	V537 In Ambleside's initial interpretation of 27E .0108, it was understood that any intervention program accepted by the State of North Carolina and DHSR would constitute as meeting this requirement. After receiving this deficiency, it is not understood that all Ambleside, Inc. staff members must be trained in the program utilized by the agency (at this time, NCI+). This policy has been revised, and is effective immediately for all	1/1/21

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V 537	Continued From page 12 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 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 use of restraint throughout the duration of the restrictive intervention;	V 537	Ambleside, Inc. staff members. In order to work with an individual served by Ambleside, the staff member must be trained in NCI+, no exceptions or alternatives will be permitted. Furthermore, any outstanding staff members that do not meet this qualification as revised will be instructed to attend the next NCI+ training held by Ambleside in order to be in compliance with this policy change. The HR Coordinator of Ambleside will be responsible for reviewing incoming staff member's certifications to ensure this policy is upheld, and will be responsible for ensuring current staff members are present in the next training, and removed from the schedule if they do not attend.	

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V 537	Continued From page 13 (6) prohibited procedures; (7) debriefing strategies, including their importance and purpose; and (8) documentation methods/procedures. (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 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	V 537		

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V 537	Continued From page 14 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 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: (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	V 537		

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V 537	Continued From page 15 train-the-trainer instruction. (m) Documentation shall be the same preparation as for trainers. This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to train staff in seclusion, physical restraint, and isolation time-out prior to delivery of services for 1 of 3 staff (Day Support Worker 1). The findings are: Review on 12/02/20 of Day Support Worker 1's personnel record revealed: - Hire date 4/26/13. - CPI (Crisis Prevention Institute) Nonviolent Crisis Intervention Refresher expiration date 2/20/21. - No documentation of training in NCI+ (National Crisis Interventions Plus). During interview on 12/02/20 Day Support Worker 1 stated: - He worked one on one with client #3; while he did not provide residential services, he did provide client #3 behavioral support in the facility if needed. - He was trained in CPI, which was "hands off." - He did not use any therapeutic holds July - October 2020. - He had not worked at Ambleside in approximately one and a half months. During interviews on 12/02/20 and 12/15/20 the Director of Operations stated: - Ambleside used the NCI+ curriculum for staff training in seclusion, physical restraint and	V 537		

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V 537	Continued From page 16 isolation time out. - If a staff was hired and had current training in another State approved curriculum, Ambleside accepted that training and did not require the staff to complete training in NCI+. - Day Support Worker 1 was trained in CPI for his primary job at a nearby state operated facility; his CPI training was up to date. - Day Support Worker 1 had not worked at Ambleside since October 22, 2020. - He would notify the Human Resources Director of the requirement for all staff to complete the same training curriculum. - Day Support Worker 1 had been scheduled for NCI+ training. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 537		
V 736	27G .0303(c) Facility and Grounds Maintenance 10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS (c) Each facility and its grounds shall be maintained in a safe, clean, attractive and orderly manner and shall be kept free from offensive odor. This Rule is not met as evidenced by: Based on observation and interview, the facility was not maintained in a clean, attractive and orderly manner. The findings are: Observation on 03/20/19 between 10:30am and 11:30am revealed:	V 736	V736 All areas that require maintenance will be addressed by the Ambleside, Inc Maintenance Supervisor, and all areas that pertain to cleanliness will be addressed by the staff members that work at the Hopewell house. The Director of Operations will verify that all maintenance items have been corrected within 30 days, and the Service Coordinator QP who oversees the home will	1/14/21

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V 736	Continued From page 17 -Living room window sill had numerous dead bugs, several tears in the linoleum at the carport entrance of the facility, black molding strip at living room entrance lifted up. -The floor in the kitchen was scattered with food, debris and dirt. Approximately 10 inch patch of linoleum missing from kitchen floor in front of the sink. Black paint chipping from all kitchen cabinets and sugar was spilled on the floor of the pantry. Two kitchen cabinets missing knobs and a large brown stain on the ceiling. -The hallway in the facility had approximately 1 foot wide hole in it and sheetrock putty covered a small area beside it with wire patch showing. -The first bathroom's shoe molding around the walls was molded, shower curtain dirty and a dark ring was inside the bathtub. -Client #3's bedroom had a strong urine odor, the bedroom door frame was split with the area around the door knob broke and the linoleum floor was peeling near door -The second bathroom had shoe molding that was split into pieces and the shower was dirty. -The carpet was soiled and dirty throughout the facility. -Client #1's 5 drawer chest had missing knobs on all five drawers. -Client #1 had yellow splatter/stains on the wall behind his bedroom door. -Client #3 had a hole in his bedroom wall approximately and 1 foot tall, frame of door split. -Both return filters in ceiling hallway covered in dust. -Client #5's light switch plate on the wall beside his bed was cracked with missing pieces, cluster of yellow/brown stains/splatter on walls and a bed sheet secured at his window with approximately 3 three inch pieces of black tape at each corner of the window. -Client #4 and #6- had a bed sheet secured at the	V 736	Ensure that all cleanliness items have been addressed by staff within the 30 day period.	

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V 736	Continued From page 18 bedroom window with approximately 3 three inch pieces of black tape at each corner of the window. -Client #2's bedroom door had paint chipping off. -Soiled twin sized box spring in the backyard. Interview on 12/7/20 Staff #1 stated: -He was unaware of the stains on Client #1 and #5 walls. -The hole in the hallway had been there for about one month. -Client #3 and Client #5 put the hole in the wall in the hallway while having behaviors. -Client #3 broke his bedroom door during behaviors. -They used the black tape and sheets because the client's broke the curtain rods. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 736		