STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL001-256	A. BUILDING: _____ B. WING _____	R-C 02/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
R & S INDEPENDENT HEALTH SERVICES, INC	636 GUNN STREET BURLINGTON, NC 27217

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 000	INITIAL COMMENTS A complaint and follow up survey was completed on February 5, 2021. The complaint was substantiated (intake #NC00172503). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600A Supervised Living for Adults with Mental Illness	V 000	DHSR - Mental Health MAR 1 0 2021 Lic. & Cert. Section	
V 113	27G .0206 Client Records 10A NCAC 27G .0206 CLIENT RECORDS (a) A client record shall be maintained for each individual admitted to the facility, which shall contain, but need not be limited to: (1) an identification face sheet which includes: (A) name (last, first, middle, maiden); (B) client record number; (C) date of birth; (D) race, gender and marital status; (E) admission date; (F) discharge date; (2) documentation of mental illness, developmental disabilities or substance abuse diagnosis coded according to DSM IV; (3) documentation of the screening and assessment; (4) treatment/habilitation or service plan; (5) emergency information for each client which shall include the name, address and telephone number of the person to be contacted in case of sudden illness or accident and the name, address and telephone number of the client's preferred physician; (6) a signed statement from the client or legally responsible person granting permission to seek emergency care from a hospital or physician; (7) documentation of services provided; (8) documentation of progress toward outcomes;	V 113	The plan of correction that has been put in place is the follow: A new face sheet with R&S Independent Health Services Inc has been created and placed in each members files. Along with updating name the current information which includes last name, first name, D.O.B Client need race, gender & marital status. This will be continuously monitored by Qualified Professional and Quality Assurance Team and Owner. Each quarter all records and files will be reviewed.	2/6/2021

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: OWNER — (X6) DATE: 2/26/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL001-256	A. BUILDING: _____ B. WING _____	R-C 02/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
R & S INDEPENDENT HEALTH SERVICES, INC	636 GUNN STREET BURLINGTON, NC 27217

(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 113	Continued From page 1 (9) if applicable: (A) documentation of physical disorders diagnosis according to International Classification of Diseases (ICD-9-CM); (B) medication orders; (C) orders and copies of lab tests; and (D) documentation of medication and administration errors and adverse drug reactions. (b) Each facility shall ensure that information relative to AIDS or related conditions is disclosed only in accordance with the communicable disease laws as specified in G.S. 130A-143. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure records were complete for three of three current clients (#1, #2 and #3). The findings are: a. Review of client #1's record on 2/2/21 revealed: -Admission date of 11/25/16. -Diagnoses of Schizophrenia-Paranoid Type, Personality Disorder, Uncontrolled Diabetes Mellitus, Hypertension, Hypothyroidism, Ataxia, Sleep Apnea. -The face sheet was completed by previous provider. -The emergency information was completed by previous provider. -The permission to seek emergency care was completed by previous provider. -There was no way to determine if the above information was current for client #1 because it	V 113		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL001-256	A. BUILDING: _____ B. WING _____	R-C 02/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
R & S INDEPENDENT HEALTH SERVICES, INC	636 GUNN STREET BURLINGTON, NC 27217

(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 113	Continued From page 2 was completed by the previous provider. b. Review of client #2's record on 2/2/21 revealed: -Admission date of 5/1/19. -Diagnoses of Schizoaffective Disorder-bipolar type and Polysubstance Abuse. -The face sheet was not completed. -The permission to seek emergency care was not completed. c. Review of client #3's record on 2/2/21 revealed: -Admission date of 1/13/17. -Diagnoses of Schizophrenia, Intellectual Delay, Cannabis Use Disorder, Alcohol Use Disorder, Hypertension and Tobacco Use. -The face sheet was completed by previous provider. -The emergency information was completed by previous provider. -The permission to seek emergency care was completed by previous provider. -There was no way to determine if the above information was current for client #3 because it was completed by the previous provider. Interview with staff #1 on 2/2/21 revealed: -The Director took over the home October 2017. -She saw the old documents in the clients records from the previous owner. -She talked with the Qualified Professional about taking the old documents out of their charts. -They had not gotten around to removing those old documents yet. -She confirmed the facility failed to ensure client records were complete. Interview with the Director on 2/3/21 revealed: -He took over the group home in September of 2017.	V 113		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL001-256	A. BUILDING: _____ B. WING _____	R-C 02/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
R & S INDEPENDENT HEALTH SERVICES, INC	636 GUNN STREET BURLINGTON, NC 27217

(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 113	Continued From page 3 -He knew some of the documents in the client records needed to be updated. -He confirmed the facility failed to ensure client records were complete. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 113		
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 reviews and interviews, the facility failed to conduct fire and disaster drills under conditions that simulate emergencies. The findings are: Review on 2/3/21 of the facility's fire drill log revealed the following: -4/5/20 2:00 PM -8/10/20 4:00 (not sure if done am or pm)	V 114	The emergency plans, disaster plan has been updated which includes the meeting places and location where all are involved, time date hours year, AM or P.M. The information has been described in details thoroughly describing all details. Each drill will be completed quarterly & monitored by qualified Professional, Quality Assurance and the owner. The description on each form will include who what, where, time and date.	2/6/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL001-256	A. BUILDING: _____ B. WING _____	R-C 02/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
R & S INDEPENDENT HEALTH SERVICES, INC	636 GUNN STREET BURLINGTON, NC 27217

(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 114	Continued From page 4 -11/12/20 2:00 (not sure if done am or pm) -1/12/21 6:00 PM -Staff did not specify which shift the fire drills were conducted. Review on 2/3/21 of the facility's disaster drill log revealed the following: -3/2020 4:00 (not sure of specific date or am/pm) -6/2020 10:00 (not sure of specific date or am/pm) -8/2020 5:00 (not sure of specific date or am/pm) -1/2021 10:00 (not sure of specific date or am/pm) -There was no disaster drill completed for the 4th quarter of 2020. -Staff did not specify which shift the disaster drills were conducted. Interview with client #1 on 2/5/21 revealed: -Staff did fire and disaster drills with them. -They had not done any fire and disaster drills in about three years or longer. Interview with client #2 on 2/5/21 revealed: -Staff used to do fire and disaster drills with them. -They had not done fire and disaster drills in a long time. -He thought they had not done fire and disaster drills in over 2 years. Interview with the Director on 2/3/21 revealed: -He had two staff working primarily at the group home. -They do there shifts with staff working 2 days on (Monday and Tuesday) and 3 days off (Wednesday, Thursday and Friday). -Then staff returns to work on Saturday and Sunday, then they start over for the week. -When one staff is off, the other person is on and working at the group home.	V 114		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL001-256	A. BUILDING: _____ B. WING _____	R-C 02/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
R & S INDEPENDENT HEALTH SERVICES, INC	636 GUNN STREET BURLINGTON, NC 27217

(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 114	Continued From page 5 -They do 24/7 shifts, so staff sleep in the home overnight. -He confirmed staff failed to conduct fire and disaster drills under conditions that simulate emergencies. This deficiency has been cited 2 time(s) since the original cite on 1/19/19 and must be corrected within 30 days.	V 114		
V 118	27G .0209 (C) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (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	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL001-256	A. BUILDING: _____ B. WING _____	R-C 02/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
R & S INDEPENDENT HEALTH SERVICES, INC	636 GUNN STREET BURLINGTON, NC 27217

(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 118	Continued From page 6 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 and interviews, the facility failed to keep the MAR current for two of three clients (#1 and #2). The findings are: a. Review of client #1's record on 2/5/21 revealed: -Admission date of 11/25/16. -Diagnoses of Schizophrenia-Paranoid Type, Personality Disorder, Uncontrolled Diabetes Mellitus, Hypertension, Hypothyroidism, Ataxia, Sleep Apnea. -Physician's order dated 10/25/19 for Albuterol Sulfate Solution 2.5 milligrams (mg)/3 milliliters (ml), inhale one vial via Nebulizer three times a day. Review of the January 2021 MAR for client #1 on 2/5/21 revealed: -There were blank boxes on 1/20-2pm dose, 1/20 pm dose and 1/21 am dose for the Albuterol Sulfate Solution 2.5 mg/3ml. b. Review of client #2's record on 2/5/21 revealed: -Admission date of 5/1/19. -Diagnoses of Schizoaffective Disorder-bipolar type and Polysubstance Abuse. -Physician's order dated 5/15/20 for Lithium ER	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL001-256	A. BUILDING: _____ B. WING _____	R-C 02/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
R & S INDEPENDENT HEALTH SERVICES, INC	636 GUNN STREET BURLINGTON, NC 27217

(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 118	Continued From page 7 300 mg, two tablets two times daily and Benztropine Mesylate 2 mg, one tablet twice daily. Review of the February 2021 MAR for client #2 on 2/5/21 revealed: -There was a blank box on 2/3 for the pm dose of Lithium ER 300 mg. -There were blank boxes on 2/4 am dose and 2/3 pm dose for Benztropine Mesylate 2 mg. Interview with staff #1 on 2/5/21 revealed: -She gave client #2 his medication on February 2nd and 3rd. -She forgot to sign of on the February MAR that the medication had been administered. -She confirmed staff failed to keep the MAR current for client #2. Interview with staff #2 on 2/5/21 revealed: -Client #1 did get his medications on the days the MAR was left blank in January 2021. -He forgot to document the medication had been administered. -He confirmed staff failed to keep the MAR current for client #1. Interview with Director on 2/5/21 confirmed: -The facility staff failed to keep the MAR's current for clients #1 and #2. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 118		
V 121	27G .0209 (F) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (f) Medication review:	V 121		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL001-256	A. BUILDING: _____ B. WING _____	R-C 02/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
R & S INDEPENDENT HEALTH SERVICES, INC	636 GUNN STREET BURLINGTON, NC 27217

(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 8 (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 record review and interview the facility failed to obtain drug reviews every six months for one of three clients (#2) who received psychotropic drugs. The findings are: Review of client #2's record on 2/2/21 revealed: -Admission date of 5/1/19. -Diagnoses of Schizoaffective Disorder-bipolar type and Polysubstance Abuse. -Physician's order dated 5/15/20 for Lithium ER 300 milligrams (mg), two tablets two times daily; Benztropine Mesylate 2 mg, one tablet twice daily and Invega Sustenna 234 mg/1.5 milliliters (ml) Intramuscularly once a month. -There was no evidence of a six months psychotropic drug review for client #2. Review of the Medication Administration Record (MAR) chart for client #2 on 2/3/21 revealed: -The January and February 2021 MAR's indicated client #2 was administered the above medications.	V 121	The MAR book has been completed by staff providing staff initials. The MAR book is in correct order when it is being monitored on a weekly basis by D.P. Nurse and the owner. The six month med review has been completed and placed in the members file. 2/6/21	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL001-256	A. BUILDING: _____ B. WING _____	R-C 02/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
R & S INDEPENDENT HEALTH SERVICES, INC	636 GUNN STREET BURLINGTON, NC 27217

(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 9 Interview with the Director on 2/5/21 revealed: -He thought client #2's six months psychotropic drug review was completed the same time as the other clients. -He was not sure why the six months psychotropic drug review was not in client #2's record. -He confirmed there was no documentation of a six months psychotropic drug review for client #2. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 121		
V 290	27G .5602 Supervised Living - Staff 10A NCAC 27G .5602 STAFF (a) Staff-client ratios above the minimum numbers specified in Paragraphs (b), (c) and (d) of this Rule shall be determined by the facility to enable staff to respond to individualized client needs. (b) A minimum of one staff member shall be present at all times when any adult client is on the premises, except when the client's treatment or habilitation plan documents that the client is capable of remaining in the home or community without supervision. The plan shall be reviewed as needed but not less than annually to ensure the client continues to be capable of remaining in the home or community without supervision for specified periods of time. (c) Staff shall be present in a facility in the following client-staff ratios when more than one child or adolescent client is present: (1) children or adolescents with substance abuse disorders shall be served with a minimum of one staff present for every five or fewer minor clients present. However, only one staff need be present during sleeping hours if specified by the	V 290	An assessment for unsupervised time has been created and currently being used. Along with the policy revision on how that unsupervised time in the home and/or community has been put in place. This plan will be assessed on a monthly basis by Qualified Professional and done with all individual information will be documented and	3/8/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL001-256	A. BUILDING: _____ B. WING _____	R-C 02/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
R & S INDEPENDENT HEALTH SERVICES, INC	636 GUNN STREET BURLINGTON, NC 27217

(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 290	Continued From page 10 emergency back-up procedures determined by the governing body; or (2) children or adolescents with developmental disabilities shall be served with one staff present for every one to three clients present and two staff present for every four or more clients present. However, only one staff need be present during sleeping hours if specified by the emergency back-up procedures determined by the governing body. (d) In facilities which serve clients whose primary diagnosis is substance abuse dependency: (1) at least one staff member who is on duty shall be trained in alcohol and other drug withdrawal symptoms and symptoms of secondary complications to alcohol and other drug addiction; and (2) the services of a certified substance abuse counselor shall be available on an as-needed basis for each client. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to assess client's capability of having unsupervised time in the home without staff supervision affecting four of five clients (#1, #3, #4 and #5). The findings are: a. Review on 2/2/21 of client #1's record revealed: -Admission date of 11/25/16. -Diagnoses of Schizophrenia-Paranoid Type, Personality Disorder, Uncontrolled Diabetes Mellitus, Hypertension, Hypothyroidism, Ataxia, Sleep Apnea. -There was no documentation that client #1 had been assessed for capability of having	V 290	recorded.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL001-256	A. BUILDING: _____ B. WING _____	R-C 02/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
R & S INDEPENDENT HEALTH SERVICES, INC	636 GUNN STREET BURLINGTON, NC 27217

(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 290	Continued From page 11 unsupervised time in the home without staff supervision. b. Review on 2/2/21 of client #3's record revealed: -Admission date of 1/13/17. -Diagnoses of Schizophrenia, Intellectual Delay, Cannabis Use Disorder, Alcohol Use Disorder, Hypertension and Tobacco Use. -There was no documentation that client #3 had been assessed for capability of having unsupervised time in the home without staff supervision. c. Review on 2/3/21 of client #4's record revealed: -Admission date of 1/13/17. -Diagnoses of Schizoaffective Disorder-Depressed Type, Attention Deficit Hyperactivity Disorder, Autistic Disorder, Tobacco Use Disorder, Gastroesophageal Reflux Disease. -There was no documentation that client #4 had been assessed for capability of having unsupervised time in the home without staff supervision d. Review on 2/3/21 of client #5's record revealed: -Admission date of 1/2/16. -Diagnoses of Mood Disorder, Attention Deficit Disorder, Sleep Disturbance, Hyperlipidemia, Hypertriglyceridemia, Vitamin D Deficiency, Gastroesophageal Disease and Acne. -There was no documentation that client #5 had been assessed for capability of having unsupervised time in the home without staff supervision. Interview with client #1 on 2/5/21 revealed: -They are allowed to stay at the home without staff supervision.	V 290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL001-256	A. BUILDING: _____ B. WING _____	R-C 02/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
R & S INDEPENDENT HEALTH SERVICES, INC	636 GUNN STREET BURLINGTON, NC 27217

(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 290	Continued From page 12 -He thought they would stay alone 1-2 times per week for about 30 minutes to an hour. Interview with client #3 on 2/5/21 revealed: -They are allowed to stay at the group home without staff. -He was normally at home with the other guys when staff are out. -He was no sure how often they stay at home without staff supervision. -He was not sure how long staff are gone whenever they are unsupervised at the home. Interview with client #4 on 2/3/21 revealed: -He was 25 years old and he was very responsible. -He was allowed to stay at the group home without staff for a few hours. -They don't stay in the home without staff at night. -He can stay at the home without staff as much as he wants. -He will normally stay at the home unsupervised 2-3 days a week or as needed. -Sometimes staff may have to run out for about 30 minutes and would leave them all at the home unsupervised. Interview with client #5 on 2/3/21 revealed: -They are allowed to stay at the group home without staff during the day. -He does not like to go out very often and prefers to be at the home alone. -He normally stays at the home without staff supervision 1-2 days a week for an hour or two. Interview with staff #1 on 2/5/21 revealed: -Occasionally clients #1, #4 and #5 would stay at the group home without staff. -Clients #2 and #3 can't be left unsupervised at the group home.	V 290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL001-256	A. BUILDING: _____ B. WING _____	R-C 02/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
R & S INDEPENDENT HEALTH SERVICES, INC	636 GUNN STREET BURLINGTON, NC 27217

(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 290	Continued From page 13 -Sometimes she may run out to do a quick errand and leave clients' #1, #4 and #5 at the home unsupervised. -They will only stay at the home without staff for an hour or less. -She thought those clients stayed at the home without staff only 2-3 times a month. Interview with the Director on 2/5/21 revealed: -He was aware that clients #4 and #5 stayed at the home alone without staff supervision. -He did not think the other three clients were at the home without staff supervision. -He did not think it was an issue for clients #4 and #5 to be at the home without staff supervision. -Those guys had been doing that ever since he took over the home about three years ago. -In his three years of having surveys no one had ever told him an assessment was needed. -He was not aware a clients ability to have unsupervised time at home needed to be assessed. -He thought clients #4 and #5's treatment plans had unsupervised at home. -He confirmed the facility failed to assess clients #1, #3, #4 and #5 capability of having unsupervised time at home.	V 290		
V 291	27G .5603 Supervised Living - Operations 10A NCAC 27G .5603 OPERATIONS (a) Capacity. A facility shall serve no more than six clients when the clients have mental illness or developmental disabilities. Any facility licensed on June 15, 2001, and providing services to more than six clients at that time, may continue to provide services at no more than the facility's licensed capacity. (b) Service Coordination. Coordination shall be	V 291	Continuous training will be completed on a monthly basis while Qualified Professional, Nurse and Director will monitor the M.A.R.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL001-256	A. BUILDING: _____ B. WING _____	R-C 02/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
R & S INDEPENDENT HEALTH SERVICES, INC	636 GUNN STREET BURLINGTON, NC 27217

(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 291	Continued From page 14 maintained between the facility operator and the qualified professionals who are responsible for treatment/habilitation or case management. (c) Participation of the Family or Legally Responsible Person. Each client shall be provided the opportunity to maintain an ongoing relationship with her or his family through such means as visits to the facility and visits outside the facility. Reports shall be submitted at least annually to the parent of a minor resident, or the legally responsible person of an adult resident. Reports may be in writing or take the form of a conference and shall focus on the client's progress toward meeting individual goals. (d) Program Activities. Each client shall have activity opportunities based on her/his choices, needs and the treatment/habilitation plan. Activities shall be designed to foster community inclusion. Choices may be limited when the court or legal system is involved or when health or safety issues become a primary concern. This Rule is not met as evidenced by: Based on observations, record review and interviews, the facility failed to assure service coordination was maintained between the facility operator and the Qualified Professionals (QPs) responsible for treatment/habilitation affecting one of three clients (#1). The findings are: The following is evidence the facility failed to coordinate services to address a medication issue for client #1. Review on 2/2/21 of client #1's record revealed: -Admission date of 11/25/16. -Diagnoses of Schizophrenia-Paranoid Type, Personality Disorder, Uncontrolled Diabetes	V 291	ensuring the correct initial start dates are placed in the proper area. Staff, D.P. Nurse and Owner will Verify that all treatment plans are current and up to date	3/8/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL001-256	A. BUILDING: _____ B. WING _____	R-C 02/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
R & S INDEPENDENT HEALTH SERVICES, INC	636 GUNN STREET BURLINGTON, NC 27217

(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 291	Continued From page 15 Mellitus, Hypertension, Hypothyroidism, Ataxia, Sleep Apnea. -A physician's order dated 1/4/21 for Haldol 2 milligrams (mg), one tablet at bedtime. -A discontinuation order dated 1/4/21 for Haldol 5 mg, one tablet at bedtime. Observation on 2/5/21 at approximately 9:45 am of the medication area for client #1 revealed: -There were no Haldol 2 mg tablets available. -There was a packet of Haldol 5 mg tablets. -Staff #2 looked in medication closet and could not locate the Haldol 2 mg tablets. Observation on 2/5/21 at approximately 11:45 am of the medication area for client #1 revealed: -Staff #1 looked in the medication closet and obtained a packet of Haldol 2 mg tablets. -There were 30 doses of Haldol 2 mg tablets in the packet. Review of the Medication Administration Record (MAR) chart for client #1 on 2/5/21 revealed: -February 2021-It was documented client #1 received 2 mg of Haldol 2/1 thru 2/4. -January 2021-It was documented client #1 received 5 mg of Haldol 1/5 thru 1/31. Interview with staff #1 on 2/5/21 revealed: -Client #1 had a medical appointment with his psychiatrist on 1/4/21. -She was off shift, she thought staff #2 worked that day. -She thought the change to the Haldol was made during that appointment. -She had been giving client #1 the 5 mg of the Haldol. -She had been waiting on the order for the Haldol 2 mg tablets . -She noticed there was a change on client #1's	V 291		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL001-256	A. BUILDING: _____ B. WING _____	R-C 02/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
R & S INDEPENDENT HEALTH SERVICES, INC	636 GUNN STREET BURLINGTON, NC 27217

(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 291	Continued From page 16 February 2021 MAR. -The MAR that had the 2 mg Haldol listed, however she did not have an order to reflect that change. -The 2 mg doses of Haldol were delivered to the home in January 2021. -She did not put the packet of Haldol 2 mg with the other medications. -She did not want the medication to be administered until they got the order from the medical office. -She spoke with someone from the psychiatrist office about having the order faxed to the home in January. -She could not remember the specific date. -She just spoke with a lady from medical office on 2/5/21. -The lady told her they mailed the physician's order for the Haldol 2 mg tablets to the group home. -She never seen the order at the group home for the Haldol 2 mg tablets. Interview with staff #2 on 2/5/21 revealed: -He thought client #1 was getting ½ Haldol pill towards the end of last month. -He normally did not do the clients medical appointments. -He thought the pharmacy only sent about 4-5 of the ½ pill doses of the Haldol. -He had been giving client #1 the 5 mg dose of Haldol. -Staff #1 would be the best person to talk to about the Haldol. -He really was not sure what was going on with client #1's Haldol. -He did recall client #1 having a medical appointment on 1/4/21 with his psychiatrist on Zoom. -They were sitting in the same area, however he	V 291		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL001-256	A. BUILDING: _____ B. WING _____	R-C 02/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
R & S INDEPENDENT HEALTH SERVICES, INC	636 GUNN STREET BURLINGTON, NC 27217

(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 291	Continued From page 17 could hear the conversation between client #1 and the psychiatrist. -He did not know client #1's medication was changed during that appointment. Interview with the Director on 2/5/21 revealed: -He never saw an order for the Haldol 2 mg tablets for client #1. -He did not think the medical office ever mailed an order to the group home. -They have a nurse that comes to the home twice a month. -The nurse never mentioned there were any issues with the Haldol for client #1. 2. The following is evidence the facility failed to coordinate services to address an issue with client #1 missing medical appointments. Interview with client #1 on 2/5/21 revealed: -He missed an appointment about 2 months ago with his medical physician. -He could not remember if he had missed any other appointments within the last few months. Interview with staff #1 on 2/5/21 revealed: -She thought client #1 possibly missed two medical appointments within the last few months. -She could not remember why the appointments were missed. -Client #1's mother would sometimes make an appointment for him. -Client #1's mother does not always tell them about the appointment. Interview with front desk staff at psychiatrist office on 2/3/21 revealed: -Client #1 was a patient at the clinic. -Client #1 had just recently missed an appointment at the clinic.	V 291		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL001-256	A. BUILDING: _____ B. WING _____	R-C 02/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
R & S INDEPENDENT HEALTH SERVICES, INC	636 GUNN STREET BURLINGTON, NC 27217

(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 291	Continued From page 18 -Client #1 missed his appointment on 1/11/21. -The appointment for client #1 was cancelled. Interview with a Nurse at the medical clinic on 2/4/21 revealed: -Client #1 was a patient at their clinic. -In 2020 she thought client #1 had at least 10 appointments cancelled, changed or he showed up late. -Within the last seven months client #1 missed 3-4 appointments. -Client #1 also showed up late for one appointment. -On 12/18/20 client #1 missed an appointment for a follow up to his blood work. -His appointment on 12/11/20 was changed the morning of the appointment to a later time that afternoon. -Client #1 also had cancelled appointments on 8/25/20 and 7/7/20. -Staff #1 changes or cancels appointments for client #1 quite often. -Staff #1's excuse would normally be that she over sleep or that she just could not make it on time. -They are not able to leave a message on staff #1' cell phone voice mail. Interview with the Director on 2/5/21 revealed: -He was aware client #1 missed a few medical appointments. -He thought most of the missed appointments was around April 2020. -Some of the appointments he cancelled and/or rescheduled. -He was concerned about COVID 19. -He felt like the clients should not go into the medical office. -He wanted the clients to do telemedicine. -Sometimes client #1's mother would schedule an	V 291		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL001-256	A. BUILDING: _____ B. WING _____	R-C 02/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
R & S INDEPENDENT HEALTH SERVICES, INC	636 GUNN STREET BURLINGTON, NC 27217

(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 291	Continued From page 19 appointment. -Staff were not always aware that client #1's mother had scheduled an appointment. -He was not aware of any recent medical appointments being cancelled for client #1.	V 291		
V 536	27E .0107 Client Rights - Training on Alt to Rest. Int. 10A NCAC 27E .0107 TRAINING ON ALTERNATIVES TO RESTRICTIVE INTERVENTIONS (a) Facilities shall implement policies and practices that emphasize the use of alternatives to restrictive interventions. (b) Prior to providing services to people with disabilities, staff including service providers, employees, students or volunteers, shall demonstrate competence by successfully completing training in communication skills and other strategies for creating an environment in which the likelihood of imminent danger of abuse or injury to a person with disabilities or others or property damage is prevented. (c) Provider agencies shall establish training based on state competencies, monitor for internal compliance and demonstrate they acted on data gathered. (d) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (e) Formal refresher training must be completed by each service provider periodically (minimum annually). (f) Content of the training that the service provider wishes to employ must be approved by	V 536	Training has been conducted by D.P. for each member, illustrating and demonstrating all areas within all areas. The D.P. will monitor all trainings as well as conduct training with staff and users. Refresher course will be completed annually. 2/16/21	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL001-256	A. BUILDING: _____ B. WING _____	R-C 02/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
R & S INDEPENDENT HEALTH SERVICES, INC	636 GUNN STREET BURLINGTON, NC 27217

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 536	Continued From page 20 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 and assisting in the person's involvement in making 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	V 536		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL001-256	A. BUILDING: _____ B. WING _____	R-C 02/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
R & S INDEPENDENT HEALTH SERVICES, INC	636 GUNN STREET BURLINGTON, NC 27217

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 536	Continued From page 21 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. (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	V 536		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL001-256	A. BUILDING: _____ B. WING _____	R-C 02/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
R & S INDEPENDENT HEALTH SERVICES, INC	636 GUNN STREET BURLINGTON, NC 27217

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 536	Continued From page 22 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. This Rule is not met as evidenced by: Based on record reviews and interview, the facility failed to ensure two of three staff (#1 and #2) had training on the use of alternatives to restrictive interventions prior to providing services. The findings are: a. Review on 2/3/21 of the facility's personnel files revealed: -Staff #1 had a hire date of 10/10/17. -Staff #1 was hired as a Habilitation Technician. -Staff #1 had a Adaptive De-escalation Alternatives training certificate that expired 10/31/20.	V 536		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL001-256	A. BUILDING: _____ B. WING _____	R-C 02/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
R & S INDEPENDENT HEALTH SERVICES, INC	636 GUNN STREET BURLINGTON, NC 27217

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 536	Continued From page 23 b. Review on 2/3/21 of the facility's personnel files revealed: -Staff #2 had a hire date of 7/2018 (no specific day). -Staff #2 was hired as a Habilitation Technician. -Staff #2 had a Adaptive De-escalation Alternatives training certificate that expired 10/31/20. Interview with the Director on 2/3/21 revealed: -The facility used Adaptive De-escalation Alternatives training on the use of alternatives to restrictive interventions. -He spoke with a trainer about the alternatives to restrictive interventions training. -The trainer had not been doing training in person due to COVID 19. -The Qualified Professional was also a trainer for a different state approved training. -He thought they would possibly be doing that training instead of the Adaptive De-escalation Alternatives. -He confirmed staff #1 and staff #2 had no current training on the use of alternative to restrictive intervention. This deficiency has been cited 2 time(s) since the original cite on 1/19/19 and must be corrected within 30 days.	V 536		
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.	V 736	The facility has been thoroughly cleaned by all staff, Qualified Professional and nurses.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL001-256	A. BUILDING: _____ B. WING _____	R-C 02/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
R & S INDEPENDENT HEALTH SERVICES, INC	636 GUNN STREET BURLINGTON, NC 27217

(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 736	Continued From page 24 This Rule is not met as evidenced by: Based on observation and interviews, the facility failed to ensure facility grounds were maintained *in a safe, clean, attractive, orderly manner and* kept free from offensive odor. The findings are: Observation on 2/2/21 at approximately 1:15 PM of the facility revealed the following issues: -Den area- There was a strong urine smell. The coffee table was dusty and had a tube of lotion, a tube of cream, glucometer, roll of toilet paper, pieces of mail, an inhaler, three coasters, a remote control, a nail clipper and breath mints on it. There were black and reddish markings on the walls. -Dining room-There was a strong urine smell. There were black markings and stains on the walls. A hole approximately one inch long was behind the door. The top of the trash can had food debris. There were 4 disposable cups on the table. -Kitchen area-There were grease stains on the wall over the stove. There were approximately 10 pea sized holes in the wall. The cabinet doors would not close all the way. The trash can had food debris on it. The refrigerator handle had tape on it. There was a faded paint area over the stove. -Client #2's bedroom-There was a crack in the door approximately four inches long. The blinds were broken. There were markings on the walls and 3 pea sized holes in wall. -Bathroom #2-The rug was bunched up on the floor. The tub had dirt and soap scum stains. The walls were stained. The shower curtain was	V 736	The area has been cleaned & dusted while removing all unnecessary items from the tables. The odor of the interior of the facility has been marked by the owner in which the landlord has been notified, work corrections has been made by the owners of the facility. The owners will ensure the facility be kept in workable order and corrections by the landlord of the property has been put in work order that will remain in place. 2/22/21	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL001-256	A. BUILDING: _____ B. WING _____	R-C 02/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
R & S INDEPENDENT HEALTH SERVICES, INC	636 GUNN STREET BURLINGTON, NC 27217

(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 736	Continued From page 25 peeling. The sink and counter top had dirt stains. The bowl, seat and rim of the toilet were all stained. The light switch was cracked. -Bathroom #1-The shower curtain had soap scum on it. The walls had grease spots. The counter top and sink had dirt stains. -Client #3's bedroom- The walls had black markings. -Patio area- There was a mop bucket, milk crate, recycle container with aluminum cans in it, a trash can, broom, grill, chair with torn cushion and 2 plastic chairs. Interview with staff #1 on 2/2/21 revealed: -She did not have a chance to clean the home for the day. -The Director knows about some of the maintenance issues with the home. -The landlord was also aware of some of the maintenance issues with the home. -She was not sure of the source of the strong urine smell. -She confirmed the facility failed to ensure facility grounds were maintained in a safe, clean, attractive, orderly manner and kept free from offensive odor. Interview with the Director on 2/3/21 revealed: -He was aware of some of the maintenance issues with the home. -He had been talking with the landlord about doing some of those repairs for the last two years. -The landlord said he would make the repairs, however he never did. -He confirmed the facility failed to ensure facility grounds were maintained in a safe, clean, attractive, orderly manner and kept free from offensive odor.	V 736		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL001-256	A. BUILDING: _____ B. WING _____	R-C 02/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
R & S INDEPENDENT HEALTH SERVICES, INC	636 GUNN STREET BURLINGTON, NC 27217

(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 736	Continued From page 26 This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 736		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
MHL001-256 Y1	A. Building B. Wing Y2	2/5/2021 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
R & S INDEPENDENT HEALTH SERVICES, INC	636 GUNN STREET BURLINGTON, NC 27217

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix V0107 Reg. # 27G .0202 (A-E) LSC	Correction Completed 02/05/2021	ID Prefix V0108 Reg. # 27G .0202 (F-I) LSC	Correction Completed 02/05/2021	ID Prefix V0112 Reg. # 27G .0205 (C-D) LSC	Correction Completed 02/05/2021
ID Prefix V0133 Reg. # G.S. 122C-80 LSC	Correction Completed 02/05/2021	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
			Kimberly R Sauls	2/10/21
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON 9/12/2019

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO