STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			7 20.2510.		R-C	
		MHL092-573	B. WING			20/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MEEKS #	#2		SEMONT RO			
	· -	WENDEL	L, NC 27591			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
V 000	INITIAL COMMENT	TS .	V 000			
	on 04/20/21. The co (intake #NC001749	low up survey was completed omplaint was substantiated. 22). Deficiencies were cited.				
	category:10A NCAC	sed for the following service C 27G .5600C Supervised h Developmental Disability.				
V 108	27G .0202 (F-I) Per	sonnel Requirements	V 108			
	(g) Employee training provided and, at a refollowing: (1) general organiz (2) training on clier delineated in 10A Nounce	cation shall be documented. Ing programs shall be minimum, shall consist of the cational orientation; It rights and confidentiality as CAC 27C, 27D, 27E, 27F and It the mh/dd/sa needs of the In the treatment/habilitation tious diseases and				

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

(X6) DATE TITLE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING:		R-C	
		MHL092-573	B. WING			2 <mark>0/2021</mark>
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MEEKS	#2		GEMONT RO L, NC 27591			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
V 108	Continued From pa	ige 1	V 108			
	and communicable clients.	diseases of personnel and				
	interviews, the facil (#1, #2, Licensee a	eviews, observation and ity failed to assure 4 of 4 staff and Qualified Professional) diopulmonary Resuscitation				
	the following: -Hired: 11/26/19 -Training: 03/22/21 ce CPR/First Aid 03/22/21 ce	ertification for Adult and Child ertificates for Evidence Based tion (EBPI) Base Plus and				
	the following: -Hired: 02/01/1 -Training: 03/22/21 ce CPR/First Aid 03/22/21 ce	1 of staff #2's record revealed 7 ertification for Adult and Child ertificates for EBPI Base Plus ministration Training				
	revealed the followi -Training: 03/22/21 ce CPR/First Aid	1 of the Licensee's record ing: ertification for Adult and Child ertificates for EBPI Base Plus				

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STATE FORM PKOK11 If continuation sheet 2 of 29

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		MHL092-573	B. WING		R- 04/2	-C 20/2021
NAME OF PROVIDER OR SI	UPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MEEKS #2			SEMONT RO L, NC 27591			
PREFIX (EACH DE	FICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
Review on OProfessional -Hired: 2 -Training 03/2 CPR/First A 03/2 and Medical Review on OPR/First A following: -03/22/2 signatures in the Qualified #1 attended -Handw times down the other has Observation 11:00am-3:3 -Two Divisit to three DHSR (Divisit to three) Training and Training and Training and	tion Adi 03/24/2 l's reco 2009 g: 22/21 ci id 22/21 ci id 22/21 ci id 22/21 ci id and I 24/05/2 id and I 21 CPR nclusive d Profe the CF ritten n but hal alf in the a on 03/ 30pm re HSR sta facilitie sion of nsite en 1:30 ent loca view on aining w g was 0 EBPI g starte pm s the tra	ministration Training 1 of the Qualified rd revealed the following: ertification for Adult and Child ertificates for EBPI Base Plus ministration Training 1 of fax submitted by the EBPI Instructor revealed the /First Aid logs noted a roster 4 e of staff #2, the Licensee and esional (QP). No notation staff PR/First Aid training. Ote: "Sorry, I didn't have the f was done in the morning and evening into the night." 22/21 at approximately evealed: aff initiated an unannounced es managed by this Licensee. Health Service Regulation) pm-3:30 pm, DHSR staff were ations simultaneously. 1 03/30/21 staff #1 reported: vas 2 weeks ago CPR/First Aid, Medication and at 5:00pm and ended siners name was [trainer's first processed of the company of the compan	V 108			

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STATE FORM PKOK11 If continuation sheet 3 of 29

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		MHL092-573	B. WING			R-C 20/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MEEKS	#2		SEMONT ROAL, NC 27591			
(V4) ID	STIMMADV STA	TEMENT OF DEFICIENCIES	1	PROVIDER'S PLAN OF CORF	PECTION	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
V 108	Continued From pa	ge 3	V 108			
	she: -Attended the treetificates -Estimated the and lasted until 9:00 -Did not scheduled by During interview on CPR/First Aid and Elements of the consist CPR/First Aid and Elements of training was a refree 1/2 hours to review -The first cleases on the came back after training. -The second claught between 5:30 -Each staff sign of 9 participants we classes.	ule the trainings. Trainings the Licensee. 04/01/21, the instructor for EBPI reported: y, she taught two separate ted of a combination of EBPI. As the CPR/First Aid sher, CPR/First Aid took to 2-2 and test on March 27th. ass was split into two 9-12 Noon, she taught a portion of EBPI. Because a medication administration, or 4:00 pm to resume the				
	the CPR/First Aid a -After the interv who reviewed the tr	nd EBPI Instructor revealed: riew, she contacted her son raining logs for this facility or this facility were taught on				
	Service Representa reported:	04/01/21, the Customer ative for CPR/First Aid				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
			A. BUILDING:		R-C	
		MHL092-573	B. WING			.0/2021
NAME OF PROVID	ER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
MEEKS #2			EMONT RO. _, NC 27591			
	EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
level to CO ques the s rene traini for Ar pract pract Durir Exec peop Unsu 04/08 inforr provi The l inope busir reque for th impo Medi Durir repoi - date - recal staff	DVID19 He was able to tions because ame for all in properties and for all in properties and the certain and child of the certain and certain and certain and certain and the certain and	apter calls were rerouted due of provide answers for training requirements were berson trainers was not a refresher, it was a tiffication. The class time and the same for any class. e of 4-5 people, the training CPR/First Aid including review, well as testing of written and d last 5-6 hours. 04/01/21, the EBPI Chief ounder reported the following: takes 1/2 day or a day for 5 apts were made on 04/01/21, //21 to obtain contact e Licensee for the person who or Medication Administration. Ited her business phone was phone number was in her none. As DHSR staff ot receive contact information Administration Instructor, it is mine the length of time for stration Training. 04/06/21, the Licensee ure when she secured the s. as all day but she did not ngs were done at once or if	V 108			

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STATE FORM PKOK11 If continuation sheet 5 of 29

DIVISION	of Health Service Re	guiation				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		MHL092-573	B. WING		R-C 04/20/2021	
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
NAIVIE OF	PROVIDER OR SUPPLIER		EMONT RO			
MEEKS	#2		L, NC 27591			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE	D BE	(X5) COMPLETE DATE
V 108	Continued From pa	ge 5	V 108			
	-"We had COVID so I set up the training" as some certificates had expired.					
V 118	27G .0209 (C) Med	ication Requirements	V 118			
	only be administered order of a person a drugs. (2) Medications shat clients only when a client's physician. (3) Medications, include administered only builticensed persons pharmacist or other privileged to prepare (4) A Medication Acall drugs administer current. Medication recorded immediate MAR is to include the (A) client's name; (B) name, strength, (C) instructions for (D) date and time the (E) name or initials drug. (5) Client requests checks shall be recorded.	inistration: non-prescription drugs shall ad to a client on the written uthorized by law to prescribe all be self-administered by uthorized in writing by the cluding injections, shall be by licensed persons, or by a trained by a registered nurse, a legally qualified person and be and administer medications. Iministration Record (MAR) of a de do each client must be kept a sadministered shall be ally after administration. The				

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FORM 6899 PKOK11 If continuation sheet 6 of 29

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			A. BUILDING:		R-	C
		MHL092-573	B. WING	· · · · · · · · · · · · · · · · · · ·		0/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MEEKS	#2		SEMONT ROAL, NC 27591			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
V 118	18 Continued From page 6		V 118			
	This Rule is not me Based on record reinterview the facility medications as ord to keep MARs curreclients (#1 and #4). #2, Licensee and C training in medication are: I. Examples of issue #1 and client #4 Review on 03/23/2 revealed: - Admission: 02/01/2 Diagnoses: Hyper Retardation, Schize Review on 03/23/2 revealed: - Admission: 01/29/2 Diagnoses: Schize of Seizure/Myoclon Review on 03/22/2 MAR revealed: - Fluticasone (used such as sneezing a nose and itchy, wat or other allergies) Sepray in each nostrethe month of March	et as evidenced by: eviews, observation and y failed to administer ered by a physician and failed ent affecting 2 of 3 audited In addition, 4 of 4 staff (#1, Qualified Professional) lacked on administration. The findings es with medications for client 1 of client #1's record /2017 rtension,Insomnia, Mental ophrenia 1 of client #4's record 2020 ophrenia, Neutropenia,History us, Vitamin D deficiency 1 of client #1's March 2021 I to relieve symptoms of rhinitis and a runny, stuffy, or itchy tery eyes caused by hay fever 50 microgram(mcg)-place 1 iil every day, was initialed for a 2021 as given				
	Parkinson's diseas due to the side effe	ed to treat symptoms of e or involuntary movements ects of certain psychiatric n(mg)- take 1 tablet by mouth				

Division of Health Service Regulation

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BOILDING.		R-C	
		MHL092-573	B. WING			0/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MEEKS	#2		GEMONT ROA L, NC 27591			
(X4) ID			ID	PROVIDER'S PLAN OF CORRECTION	ON	(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	.D BE	COMPLETE DATE
V 118	Continued From pa	ge 7	V 118			
	twice a day, was in 2021 as given	itialed for the month of March				
	Review on 03/22/2 ² MAR revealed:	1 of client #4's March 2021				
		reat certain mental/mood apsule-take 1 capsule by				
	mouth at bedtime with 10mg capsule for total dose of 35mg had no physician orders					
	Observation on 03/22/21 at 2:00pm revealed: -Client #1's Fluticasone and Benztropopine were not present in the home -Client #4's Loxapine was not present in the					
	home					
	Interview on 03/25/21 client #1 reported: -Does not know of any missed medication -Took the medication that staff would give to him -Can not name any medications					
	Interview on 03/25/21 client #4 reported: -Does not know if any missed medication -Does not know the name of medications					
	reported:	21 and 03/30/21 staff #1				
	Fluticasone, and Be and will be order to					
		ified Professional (QP) when a certain level and the QP ation				
	even though the me	ere supposed to be signed edication is not in the home hing about physician orders P or Licensee				
	Interview on 04/06/ -Responsible for or					

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
712 . 21	o. oo		A. BUILDING:		D 0	
		MHL092-573	B. WING		R- 04/2	.C 0/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET ADD	ORESS, CITY, S	STATE, ZIP CODE		
MEEKS	#2		EMONT RO. ., NC 27591			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
V 118	-Staff report when recall the pharmacy -Pharmacy delivered office same day or -She will check the medication to the half. Examples staff I administration. Review on 03/24/22-Hired: 11/26/19 -Training: 03/22/21 certific (cardiopulmonary reand Evidence Base (EBPI) Base Plus Review on 03/24/22 the following: -Hired: 02/01/12-Training: 03/22/21 certific (CPR/First Aid 03/22/21 certific and Medication Adrivevealed: -Training: 03/22/21 certific 03/22/21 certific CPR/First Aid and E	medications are low, she will ad medications to the corporate next day medication, then deliver the ome acked training in medication of staff #1's record revealed: cation for MAT (Medication ning) cates for Adult and Child esuscitation) CPR/First Aid ad Protective Intervention of staff #2's record revealed retification for Adult and Child ertificates for EBPI Base Plus ministration Training of the Licensee's record cation for MAT cates for Adult and Child	V 118	DEFICIENCY		
	03/22/21 certific	cation for MAT				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		MHL092-573	B. WING			-C 20/2021
NAME OF	PROVIDER OR SUPPLIER			TATE, ZIP CODE		
MEEKS	#2		SEMONT ROA L, NC 27591	AD.		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
V 118	03/22/21 certific CPR/First Aid and E CPR/First Aid and E Observation on 03/2 PM, two DHSR (Div Regulation) staff inithree facilities mana -Between 1:30 at two different local included this location -At this location were present. One Review on 04/05/21 CPR/First Aid and E following: -03/22/21 Rece a roster with 3 signs second roster with 4#2, the Licensee and -Handwritten not times down but half the other half in the .During interview or -Last training was C training and EBPI -Training starte around 7:00pm -"Guess the trainame] not sure of husuccessful attern 04/05/21 and 04/06 information from the Instructor. As DHSF receive contact info	cates for Adult and Child EBPI Base Plus 22/21 between 11:00 AM-3:30 vision of Health Service tiated an unannounced visit to aged by this Licensee. PM-3:30 PM, DHSR staff were tions simultaneously that on. I, the Licensee and staff #1 DHSR staff was present I of fax submitted by the EBPI instructor revealed the extification for EBPI logs noted atures inclusive of staff #1 a 4 signatures inclusive of staff ad the QP. ote: "Sorry, I didn't have the was done in the morning and evening into the night." In 03/30/21 staff #1 reported: as 2 weeks ago CPR/First Aid, Medication I at 5:00pm and ended Inters name was [trainer's first	V 118			

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
7.1.12 . 2.1.1	0. 00.1.1.20.10.1		A. BUILDING:		5.0	
		MHL092-573	B. WING		R- 04/2	-C 2 0/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MEEKS	#2		SEMONT ROA L, NC 27591			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
V 118	8 Continued From page 10		V 118			
	Licensee reported: -Her business phor -The phone numbe her business cellula -Once she obtained corporate office, sh information.	ne was inoperable or for the MAT Instructor was in our phone. It access or went to the our would provide the contact				
	Interview on 03/30/21, staff #1 reported: -Training for CPR/First Aid, MAT and EBPI was held 03/22/21 -Training lasted 4 hours in the evening.					
	Interview on 03/31/21, the QP reported she: -Attended the trainings noted on the certificates -Estimated the trainings started at 4:30pm and lasted until 9:00pm -Did not schedule the trainings. Trainings were scheduled by the Licensee.					
	EBPI Instructor rep -For this agency, st that consisted of a and EBPI per sessi refreshers, both cla hoursThe first class was Between 9am-12 N and a portion of EB teaching medicatio back after 4:00pm	21, the CPR/First Aid and orted: ne taught two separate classes combination of CPR/First Aid ion. As the trainings were asses lasted an estimated 5 is split into two sessions. Ioon, she taught CPR/First aid BPI. Because a nurse was n administration, she came to resume the training. 21, the Customer Service CPR/First Aid reported:				
	-For a class size of Adult and Child CP	4-5 people, the training for R/First Aid including review, well as testing of written and				

Division of Health Service Regulation

STATE FORM PKOK11 If continuation sheet 11 of 29

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		MHL092-573	B. WING		R-C 04/20/2021	
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	1 04/2	0/2021
MEEKS	#2		EMONT RO			
			., NC 27591			I
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
V 118	Continued From page 11		V 118			
	practical skills woul	d last 5-6 hours.				
	Officer/Founder rep	21, the EBPI Chief Executive corted the following: es 1/2 day or a day for 5				
	Interview on 04/06/21, the Licensee reported: -She was not sure when she secured the date for the trainingsThe training was all day but she did not recall if all the trainings were done at once or if staff were divided into groupsShe did not recall the time the trainings started. She did not recall if the trainings were held at different times"We had COVID (Coronavirus Disease) so I set up the training" as some certificates had expired.					
V 536	27E .0107 Client Ri Int.	ghts - Training on Alt to Rest.	V 536			
	practices that emph to restrictive interve (b) Prior to providir disabilities, staff ince employees, student demonstrate compe completing training other strategies for which the likelihood or injury to a persor property damage is (c) Provider agencies	mplement policies and nasize the use of alternatives ntions. In services to people with luding service providers, as or volunteers, shall betence by successfully in communication skills and creating an environment in of imminent danger of abuse in with disabilities or others or				

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STATE FORM PKOK11 If continuation sheet 12 of 29

MHL092-573 SUMMARY STATEMENT OF DEFICIENCES A 125 EDGEMONT ROAD PROVIDERS PLAN OF CORRECTION EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERED. EACH CORRECTION EACH CORRECTION SHOULD	STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
NAME OF PROVIDER OR SUPPLIER MEEKS #2 STREET ADDRESS, CITY, STATE, ZIP CODE 4125 EDGEMONT ROAD WENDELL, NC 27591 [ACA] ID PREFIX TAG CONTINUED FROM USET BE PRECEDED BY FULL TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) V 536 CONTINUED FROM USET BE PRECEDED BY FULL GROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) V 536 CONTINUED FROM USET BE PRECEDED BY FULL TAG CROSS-REFERENCED TO THE APPROPRIATE DATE CROSS-REFERENC							
MEEKS #2 SUMMARY STATEMENT OF DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) V 536 Continued From page 12 compliance and demonstrate they acted on data gathered. (d) The training shall be competency-based, include measurable learning objectives, measurable learning objectives, measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (e) Formal refresher training must be completed by each service provider periodically (minimum annually). (f) Content of the training that the service provider wishes to employ must be approved by the Division of MH/DD/SAS pursuant to Paragraph (g) of this Rule. (g) Staff shall demonstrate competence in the following core areas: (1) knowledge and understanding of the people being served; (2) recognizing and interpreting human behavior; (3) recognizing the effect of internal and external stressors that may affect people with disabilities; (4) strategies for building positive relationships with persons with disabilities; (5) recognizing cultural, environmental and organizational factors that may affect people with disabilities; (6) recognizing cultural, environmental and organizational factors that may affect people with disabilities;			MHL092-573	B. WING		04/2	0/2021
WENDELL, NC 27591 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) V 536 Continued From page 12 compliance and demonstrate they acted on data gathered. (d) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (e) Formal refresher training must be completed by each service provider periodically (minimum annually). (f) Content of the training that the service provider wishes to employ must be approved by the Division of MH/DD/SAS pursuant to Paragraph (g) of this Rule. (g) Staff shall demonstrate competence in the following core areas: (1) knowledge and understanding of the people being served; (2) recognizing and interpreting human behavior; (3) recognizing the effect of internal and external stressors that may affect people with disabilities; (4) strategies for building positive relationships with persons with disabilities; (5) recognizing cultural, environmental and organizational factors that may affect people with disabilities;	NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX TAG CACH DEFICIENCY MIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PROVIDERS PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE. V 536 Continued From page 12 V 536	MEEKS #	‡ 2					
PRÉFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) V 536 Continued From page 12 compliance and demonstrate they acted on data gathered. (d) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (e) Formal refresher training must be completed by each service provider periodically (minimum annually). (f) Content of the training that the service provider wishes to employ must be approved by the Division of MH/DD/SAS pursuant to Paragraph (g) of this Rule. (g) Staff shall demonstrate competence in the following core areas: (1) knowledge and understanding of the people being served; (2) recognizing and interpreting human behavior; (3) recognizing the effect of internal and external stressors that may affect people with disabilities; (4) strategies for building positive relationships with persons with disabilities; (5) recognizing cultural, environmental and organizational factors that may affect people with disabilities;				_, NC 27591			
compliance and demonstrate they acted on data gathered. (d) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (e) Formal refresher training must be completed by each service provider periodically (minimum annually). (f) Content of the training that the service provider wishes to employ must be approved by the Division of MH/DD/SAS pursuant to Paragraph (g) of this Rule. (g) Staff shall demonstrate competence in the following core areas: (1) knowledge and understanding of the people being served; (2) recognizing and interpreting human behavior; (3) recognizing the effect of internal and external stressors that may affect people with disabilities; (4) strategies for building positive relationships with persons with disabilities; (5) recognizing cultural, environmental and organizational factors that may affect people with disabilities;	PRÉFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI	D BE	COMPLETE
gathered. (d) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (e) Formal refresher training must be completed by each service provider periodically (minimum annually). (f) Content of the training that the service provider wishes to employ must be approved by the Division of MH/DD/SAS pursuant to Paragraph (g) of this Rule. (g) Staff shall demonstrate competence in the following core areas: (1) knowledge and understanding of the people being served; (2) recognizing and interpreting human behavior; (3) recognizing the effect of internal and external stressors that may affect people with disabilities; (4) strategies for building positive relationships with persons with disabilities; (5) recognizing cultural, environmental and organizational factors that may affect people with disabilities;	V 536	Continued From page 12		V 536			
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		compliance and der gathered. (d) The training shainclude measurable measurable testing behavior) on those methods to determic course. (e) Formal refreshed by each service programually). (f) Content of the training provider wishes to each service programually). (g) Staff shall demorated following core areas (1) knowledg people being served (2) recognizing behavior; (3) recognizing external stressors translities; (4) strategies relationships with programizational factor disabilities; (6) recognizing assisting in the person decisions about the (7) skills in as escalating behavior (8) communication of the co	monstrate they acted on data all be competency-based, elearning objectives, (written and by observation of objectives and measurable ine passing or failing the er training must be completed ovider periodically (minimum raining that the service employ must be approved by DD/SAS pursuant to is Rule. constrate competence in the s: e and understanding of the d; ing and interpreting human and the effect of internal and that may affect people with a for building positive ersons with disabilities; ing cultural, environmental and ors that may affect people with and the importance of and son's involvement in making sir life; cation strategies for defusing obtentially dangerous behavior;				

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		MHL092-573	B. WING			-C 2 0/2021
NAME OF	PROVIDER OR SUPPLIER	4125 EDG	DRESS, CITY, SEMONT ROLL, NC 27591			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUTH CROSS-REFERENCED TO THE APPROPRIES OF THE AP	OULD BE	(X5) COMPLETE DATE
V 536	activities which dire behaviors which are (h) Service provide documentation of ir at least three years (1) Documen (A) who partic outcomes (pass/fail (B) when and (C) instructor (2) The Divisi review/request this (i) Instructor Qualif Requirements: (1) Trainers s by scoring 100% or aimed at preventing need for restrictive (2) Trainers s by scoring a passin instructor training p (3) The trainic competency-based objectives, measura observation of behameasurable method failing the course. (4) The contestive provider pla approved by the Divito Subparagraph (i) (5) Acceptable shall include but are (A) understan (B) methods course; (C) methods performance; and	ctly oppose or replace e unsafe). It shall maintain nitial and refresher training for tation shall include: It ipated in the training and the lipated lipate	V 536			

Division of Health Service Regulation

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			D. WING		R-C	
		MHL092-573	B. WING		04/2	0/2021
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
MEEKS :	#2		EMONT ROA -, NC 27591	AD		
(X4) ID	SLIMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON.	(X5)
PREFIX TAG			PREFIX (EACH CORRECTIVE ACTION SHOULD BE		D BE	COMPLETE DATE
V 536	Continued From pa	ge 14	V 536			
V 536	(6) Trainers steaching a training reducing and elimininterventions at least review by the coach (7) Trainers staimed at preventing need for restrictive annually. (8) Trainers staining and (j) Service provided documentation of intraining for at least (1) Documentation of intraining for at least (2) The Division of instructor (3) Coaches requirements as a formal of instructor (3) Coaches the course which is (3) Coaches competence by contrain-the-trainer instructor instructor (3) Coaches competence by contrain-the-trainer instructor (4) The coaches (4) Coa	shall have coached experience program aimed at preventing, nating the need for restrictive st one time, with positive on. Shall teach a training program on the program and eliminating the interventions at least once of the shall complete a refresher of the shall complete a refresher of the shall maintain on the shall maintain on the shall maintain of the shall include: Sipated in the training and the of the shall include: Sipated in the training and the of the shall include: Sipated in the training and the of the shall include: Sipated in the training and the of the shall include: Shall meet attended; and of the shall meet all preparation of the shall include: Shall teach at least three times being coached. Shall demonstrate on pletion of coaching or	V 536			
	This Rule is not me	et as evidenced by:				

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE	SURVEY LETED
			A. BUILDING:		5.0	
		MHL092-573	B. WING		R-C 04/20/2021	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MEEKS	#2		EMONT ROA L, NC 27591	AD		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
V 536	Based on record reinterviews, the facil (#1, #2, Licensee a (QP)) were trained Interventions. The facility of the following: -Hired: 11/26/19 -Training: 03/22/21 corrective Interventions 03/22/21 corrective Of the following: -Hired: 02/01/1 -Training: 03/22/21 corrective Of the following: -Hired: 02/01/1 -Training: 03/22/21 corrective Of the following: -Training: 03/22/21 corrective Of the following	views, observation and ity failed to assure 4 of 4 staff and Qualified Professional in Alternatives to Restrictive indings are: I of staff #1's record revealed entification for Evidence Based ion (EBPI) Base Plus entificates for Adult and Child Medication Administration I of staff #2's record revealed retificates for Adult and Child Medication Administration I of the Licensee's record ng: entification for EBPI Base Plus entificates for Adult and Child Medication Administration I of the Licensee's record ng: entification for EBPI Base Plus entificates for Adult and Child Medication Administration	V 536	DEFICIENCY)		
	03/22/21 ce	ertification for EBPI Base Plus ertificates for Adult and Child Medication Administration				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		MHL092-573	B. WING		R-C 04/20/2021	
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	STATE, ZIP CODE		
MEEKS	#2		GEMONT RO L, NC 27591			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
V 536	Training Observation on 03/2 revealed: -Two DHSR stavisit to three facilities DHSR (Division of Its staff were onsite be Between 1:30 pm-3 two different locations Review on 04/05/21 CPR/First Aid and Efollowing: -03/22/21 Receared a roster with 3 signs second roster with 4/2, the Licensee and Handwritten not times down but half the other half in the During interview on Last training was Ctraining and EBPI -Training started around 7:00pm -"Guess the training was contained and started the training interview on she: -Attended the training training interview on she: -Attended the training and lasted until 9:00	22/21 from 11-00am-3:30 pm Iff initiated an unannounced as managed by this Licensee. Health Service Regulation) tween 11:00 am-3:30 pm. If initiated an unannounced as managed by this Licensee. Health Service Regulation) tween 11:00 am-3:30 pm. If initiation am-3:30 pm. If initiation pm. If initiated an unannounced are also and am-3:30 pm. If initiation am-3:30 pm. If initiation pm. If initiated an unannounced am-3:30 pm. If initiation am-3:30 pm. If initiated an unannounced am-3:30 pm. If initiation am-3:30 pm. If initiated an unannounced amanaged by this Licensee. If initiated an unannounced amanaged by the Licensee. If initiated an unannounced amanaged by the Licensee. If initiation am-3:30 pm. If initiated an unannounced amanaged by the Licensee. If initiated an unannounced amanaged by the Licensee. If initiated an unannounced amanaged by this Licensee. If initiated an unannounced amanaged by the Licensee. If initiated an unannounced and the Licensee. If initiated an unan	V 536			

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Division of Health Service Regulation STATE FORM

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _		(X3) DATE SURVEY COMPLETED	
	MHL092-573	B. WING			-C 20/2021
NAME OF PROVIDER OR SUPPLIER MEEKS #2	4125 ED0	DDRESS, CITY, ST GEMONT ROA L, NC 27591			
PREFIX (EACH DEFICIENCY MU	MENT OF DEFICIENCIES UST BE PRECEDED BY FULL IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
CPR/First Aid and EBR -For this agency, s classes on March 27th combination of CPR/F session. As the trainin classes lasted an estir CPR/First Aid and EBR review and test per top -The first class wa Between 9-12 Noon, s and a portion of EBPI. teaching medication and back after 4:00 PM to -The second class taught between 5:30-8 -Each staff signed of 9 participants were classes. Review on 04/02/21 of the CPR/First Aid and -After the interview who reviewed the train -The classes's for March 22, 2021 instea During interview on 04 Service Representative reported: -For a class size of for Adult and Child CP practice of skills as we practical skills would be Unsuccessful attempts 04/05/21 and 04/06/21 information from the L provided training for me	A/01/21, the instructor for PI reported: she taught two separate in that consisted of a First Aid and EBPI pering was a refresher, both mated 5 hours. The PI took 2-2 1/2 hour to pic. as split into two sessions. She taught CPR/First aid. Because a nurse was administration, she came resume the training. It was one session and B:30 or 9:00 pm. If the attendance log. A total enrolled between the two at the facility in this facility was taught on and of March 27, 2021. A/01/21, the Customer of the facility of the facility was taught on and of March 27, 2021. A/01/21, the Customer of the facility of the facility was taught on and of March 27, 2021. A/01/21, the Customer of the facility of the facility was taught on and of March 27, 2021. A/01/21, the Customer of the facility of the facility of the training of the facility of the facility of the facility of the training of the facility of the facili				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			71. BOILDING.		R-C	
		MHL092-573	B. WING			0/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MEEKS:	#2		EMONT RO	AD		
	OLIMAN AND PLACE OF A		L, NC 27591	PROVIDEDIO DI AMI OF CORRECTI	ON.	(1.5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
V 536	Continued From pa	ge 18	V 536			
	business cellular ph requested but did no for the medication a	phone number was in her none. As DHSR staff of receive contact information administration instructor, it is mine the length of time for tration Training.				
	Executive Officer/Formal Recertification peopleRecertification video, supplemental practice of skills and	04/01/21, the EBPI Chief ounder reported the following: takes 1/2 day or a day for 5 consisted of a 40 minute ry material, discussion, d written and physical tification in 2 hours is really				
	reported: -She was not so date for the training warecall if all the traini staff were divided in -She did not recestarted. She did no held at different time	as all day but she did not ngs were done at once or if not ogroups. It is a standard the time the trainings were the standard the trainings were es.				
V 537	10A NCAC 27E .01		V 537			
	ISOLATION TIME-(a) Seclusion, phys	sical restraint and isolation aployed only by staff who have				

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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4125 EDGEMONT ROAD WENDELL, NC 27591 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X		OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMP	
NAME OF PROVIDER OR SUPPLIER NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4125 EDGEMONT ROAD WENDELL, NC 27591 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X4)	7.11.12 1 12 11 10 1	or contraction	BERTIN 10, WIGHT WOMBER	A. BUILDING:			
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WENDELL, NC 27591 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X4) ID PROVID	NAME OF PRO	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
WENDELL, NC 27591 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X4) ID PROVID	MEEKS #2	2	4125 EDG	EMONT ROA	AD		
(X.1) 15	WEEKS #2	2	WENDELI	L, NC 27591			
	PRÉFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	.D BE	(X5) COMPLETE DATE
V 537 Continued From page 19 V 537	V 537 Co	Continued From pa	age 19	V 537			
competence in the proper use of and alternatives to these procedures. Facilities shall ensure that staff authorized to employ and terminate these procedures are retrained and have demonstrated competence at least annually. (b) Prior to providing direct care to people with disabilities whose treatment/habilitation plan includes restrictive interventions, staff including service providers, employees, students or volunteers shall complete training in the use of seclusion, physical restraint and isolation time-out and shall not use these interventions until the training is completed and competence is demonstrated. (c) A pre-requisite for taking this training is demonstrating competence by completion of training in preventing, reducing and eliminating the need for restrictive interventions. (d) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the 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	co to sta proco (b) dising se vo se an trade (c) de trathe (d) inco (e) by an (f) proto (1) the (2) (u) otl	competence in the to these procedures staff authorized to e procedures are retrompetence at least (b) Prior to providin disabilities whose to includes restrictive service providers, evolunteers shall conseclusion, physical and shall not use the training is completed demonstrated. (c) A pre-requisited demonstrating compation in preventing in preventing the need for restrictived) The training shall include measurable measurable testing behavior) on those methods to determ course. (e) Formal refreshed by each service proannually). (f) Content of the toprovider plans to enthe Division of MH/Paragraph (g) of the (g) Acceptable train but are not limited to the use of restrictives (2) guidelines (understanding immothers);	proper use of and alternatives es. Facilities shall ensure that employ and terminate these rained and have demonstrated st annually. In a direct care to people with treatment/habilitation plan interventions, staff including employees, students or emplete training in the use of a restraint and isolation time-out these interventions until the ed and competence is for taking this training is appetence by completion of an and eliminating of the interventions. In all be competency-based, the learning objectives, and we desired witten and by observation of the objectives and measurable and passing or failing the element training must be completed ovider periodically (minimum training that the service amploy must be approved by approv				

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	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE	SURVEY LETED
AND LEWIN	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING:		COMP	
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		MHL092-573	B. WING		04/20/2021	
		WII 12032-373			04/2	0/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
		4125 EDG	EMONT RO	AD		
MEEKS #	#2		_, NC 27591			
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(X4) ID		TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
PREFIX TAG		SC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROI		DATE
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V 537	Continued From pa	ge 20	V 537			
	riabte and dianity of	fall paragraphic involved (using				
		f all persons involved (using				
		estrictive interventions and				
	incremental steps in					
		for the safe implementation				
	of restrictive interve	· · · · · · · · · · · · · · · · · · ·				
		f 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;					
		I procedures;				
		strategies, including their				
	importance and pur					
		tation methods/procedures.				
	(h) Service provide					
		nitial and refresher training for				
	at least three years					
	` /	tation shall include:				
		cipated in the training and the				
	outcomes (pass/fail					
	. ,	l where they attended; and				
	(C) instructor					
	` /	ion of MH/DD/SAS may				
	review/request this	documentation at any time.				
	(i) Instructor Qualif	ication and Training				
	Requirements:	-				
		shall demonstrate competence				
		n testing in a training program				
		g, reducing and eliminating the				
	need for restrictive interventions.					
		shall demonstrate competence				
		testing in a training program				
		seclusion, physical restraint				
	and isolation time-c					
		shall demonstrate competence				
		g grade on testing in an				
	instructor training p					
	(4) The traini	ng shall be				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	MHL092-573	B. WING			-C 20/2021
NAME OF PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE		
MEEKS #2		EMONT ROA			
WIEERS #2	WENDEL	L, NC 27591			
PREFIX (EACH DEFICIENCY I	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
V 537 Continued From pag	je 21	V 537			
competency-based, objectives, measural observation of behave measurable methods failing the course. (5) The conterservice provider plant approved by the Divito Subparagraph (j)((6) Acceptable shall include, but not of: (A) understand (B) methods for course; (C) evaluation (D) documenta (T) Trainers shannually and demon of seclusion, physical time-out, as specified Rule. (8) Trainers ship in teaching the use of least two times with a coach. (10) Trainers ship instructor training at (k) Service provider documentation of initraining for at least th (1) Documental	include measurable learning ble testing (written and by vior) on those objectives and is to determine passing or and of the instructor training the inside to employ shall be ision of MH/DD/SAS pursuant 6) of this Rule. Instructor training programs to be limited to, presentation the limited to, presentation the instructor training programs to be limited to, presentation the instructor training programs to be limited to, presentation the instructor training programs to be limited to, presentation the instructor trained at least strate competence in the use at restraint and isolation do in Paragraph (a) of this intervention at a positive review by the interventions at least once in the instructor trained at least once in the instructor trained at least once in the instructor instructo				

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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		MHL092-573	B. WING		04/2	0/2021
NAME OF	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE		
MEEKS	#2		EMONT ROA L, NC 27591			
(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 537	(C) instructor (2) The Divis review/request this (I) Qualifications of (1) Coaches requirements as a t (2) Coaches times, the course w (3) Coaches competence by cor train-the-trainer ins (m) Documentation preparation as for t	I where they attended; and 's name. ion of MH/DD/SAS may documentation at any time. Coaches: shall meet all preparation trainer. shall teach at least three which is being coached. shall demonstrate inpletion of coaching or truction. In shall be the same rainers.	V 537			
	This Rule is not met as evidenced by: Based on record reviews, observation and interviews, the facility failed to assure 4 of 4 staff (#1, #2, Licensee and Qualified Professional (QP)) were trained in Restrictive Interventions. The findings are: Review on 03/24/21 of staff #1's record revealed the following: -Hired: 11/26/19 -Training: 03/22/21 certification for Evidence Based Protective Intervention (EBPI) Base Plus 03/22/21 certificates for Adult and Child CPR/First Aid and Medication Administration Training Review on 03/24/21 of staff #2's record revealed the following:					
	-Hired: 02/01/1 -Training:	7				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			A. BUILDING:		R-C	
		MHL092-573	B. WING		04/20/2021	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MEEKS	#2		EMONT ROAL, NC 27591			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
V 537	O3/22/21 cd CPR/First Aid and I Training Review on 03/24/22 revealed the followid prevention of the control of	ertification for EBPI Base Plus ertificates for Adult and Child Medication Administration 1 of the Licensee's recording: ertification for EBPI Base Plus ertificates for Adult and Child Medication Administration 1 of the Qualified rd revealed the following: ertificates for Adult and Child Medication for EBPI Base Plus ertificates for Adult and Child Medication Administration 22/21 from 11-00am-3:30 pm aff initiated an unannounced es managed by this Licensee. Health Service Regulation) etween 11:00 AM-3:30 pm. 8:30 pm, DHSR staff were at ons simultaneously.	V 537			
	CPR/First Aid and I following: -03/22/21 Rece a roster with 3 sign second roster with #2, the Licensee ar -Handwritten no	1 of fax submitted by the EBPI instructor revealed the ertification for EBPI logs noted atures inclusive of staff #1 a 4 signatures inclusive of staff and the QP. ote: "Sorry, I didn't have the f was done in the morning and				

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL092-573	MHL092-573 B. WING 04/20		-C 20/2021	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	-	
MEEKS:	#2		SEMONT ROA			
			L, NC 27591			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
V 537	Continued From pa	ge 24	V 537			
	the other half in the	evening into the night."				
	-Last training w -Training was O training and EBPI -Training starte around 7:00pm -"Guess the tra name] not sure of h During interview on she: -Attended the tr certificates -Estimated the and lasted until 9:00 -Did not schedu were scheduled by During interview on	03/31/21, the QP reported rainings noted on the trainings started at 4:30 pm 0 pm ule the trainings. Trainings the Licensee.				
	classes that consist CPR/First Aid and E training was a refre estimated 5 hours.	EBPI reported: y, she taught two separate ted of a combination of EBPI per session. As the sher, both classes lasted an The CPR/First Aid and EBPI o review and test per topic.				
	-The first class Between 9-12 Noor and a portion of EB teaching medication back after 4:00 PM -The second cla taught between 5:30 -Each staff sign	was split into two sessions. n, she taught CPR/First aid PI. Because a nurse was n administration, she came to resume the training. ass was one session and				
	Review on 04/02/21	I of a text communication from				

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL092-573	B. WING	B. WING R-C 04/20/2		-C 20/2021
	PROVIDER OR SUPPLIER		DDRESS, CITY, S	STATE, ZIP CODE		
MEEKS	#2	WENDEL	L, NC 27591			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
V 537	Continued From pa	ge 25	V 537			
V 537	the CPR/First Aid a -After the interv who reviewed the tr -The classes's March 22, 2021 ins During interview on Service Representa reported: -For a class siz for Adult and Child practice of skills as practical skills woul Unsuccessful attem 04/05/21 and 04/06 information from the provided training for The Licensee repor inoperable and the business cellular ph requested but did n for the medication a	nd EBPI Instructor revealed: riew, she contacted her son raining logs for this facility for this facility was taught on tead of March 27, 2021. 04/01/21, the Customer rative for CPR/First Aid e of 4-5 people, the training CPR/First Aid including review, well as testing of written and d last 5-6 hours. https://www.edi.com/first/firs				
	Executive Officer/Foundation -Recertification people.	04/01/21, the EBPI Chief ounder reported the following: takes 1/2 day or a day for 5 consisted of a 40 minute				
	video, supplementa practice of skills and	d written and physical tification in 2 hours is really				
	reported:	04/06/21, the Licensee ure when she secured the s.				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
7 IND 1 L7 IIV	A. BUILDING:					
		MHL092-573	B. WING		R-C 04/20/2021	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MEEKS #	#2		EMONT ROAL, NC 27591			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
V 537	recall if all the train staff were divided in -She did not re started. She did not held at different tim	as all day but she did not ings were done at once or if nto groups. call the time the trainings of recall if the trainings were es. ID so I set up the training" as	V 537			
V 736	10A NCAC 27G .03 EXTERIOR REQU (c) Each facility and maintained in a saf	ty and Grounds Maintenance 303 LOCATION AND IREMENTS If its grounds shall be e, clean, attractive and orderly e kept free from offensive	V 736			
	failed to ensure the	et as evidenced by: and observation, the facility home was maintained in a tractive manner. The findings				
	between 1:30pm-3: the following: -Hallway bathro commode was una base of the commo -Floor-wrinkling the bathroom -Bedroom -first	bedroom on the right had 5 with 1 full size head board				

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STATEMENT OF DEFICIENCIES (X) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
				R.	R-C	
		MHL092-573	B. WING	04/20/202		
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	STATE, ZIP CODE		
MEEKS	#2		SEMONT ROA L, NC 27591	AD		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT	ION	(X5)
PRÉFIX TAG		MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)		COMPLETE DATE
V 736	Continued From pa	ge 27	V 736			
	chirping on 03/22/2 Interview on 03/22/	/21, the Licensee reported:				
	-Issues/concern with the commode have been at the base, has tried to fix and maintain it herself -She was not aware of a floor buckling in the bathroom doorway					
	-Mattresses will today was intended	be moved out of bedroom #1 to be moved prior to be changed in alarms and				
V 753	27G .0304(b)(5) Inc	loor Lighting	V 753			
	EQUIPMENT (b) Safety: Each fa constructed and eq ensures the physical	cility shall be designed, uipped in a manner that al safety of clients, staff and				
	routine access shal be adequate to peri engage in normal a	areas to which clients have I be well-lighted. Lighting shall mit occupants to comfortably nd appropriate daily activities riting, working, sewing and				
	failed to ensure all i The findings are:	on and interview, the facility ndoor areas were well-lighted.				
	of the group home	22/21 between 1:30-3:30 PM revealed:				

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		MHL092-573	B. WING R-0 04/20		-C 2 0/2021		
NAME OF	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE						
MEEKS	#2		EMONT RO. L, NC 27591				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE	
V 753	-Kitchen/Dining Unable were in the overhea to see well -Living room Overhe Room was still dim During interviews of Licensee reported: -She thought th	Area to determine how many bulb ad light, area was dim unable and light and lamp as lighting. not well lit for client activities an 03/25/21 and 04/05/21, the agroup home was well lit. bulbs were purchased and	V 753				

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