STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL096-117	A. BUILDING: _____ B. WING _____	R 06/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY PINES #1	2307 NORTH BESTON ROAD LA GRANGE, NC 28551

(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 An annual, complaint and follow up survey was completed on June 24, 2021. The complaint was unsubstantiated (Intake #NC00177790). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities.	V 000		
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	DHSR - Mental Health JUL 12 2021 Lic. & Cert. Section	

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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 review and interviews, the facility staff failed to maintain a complete client record to include consent for treatment for one of one former client (FC) (#6). The findings are: Review on 06/23/21 of FC #6's record revealed: - 52 year old female. -Admission date of 01/28/21. -Discharge date of 05/18/21. - Diagnoses of Schizoaffective Disorder, Mild Mental Retardation, Hypertension, Chronic Obstructive Pulmonary Disease, Atrial Fibrillation, Diabetes Mellitus-Type 2, Hypothyroidism, Chronic Kidney Disease, Hypogonadism. - No documented consent for emergency treatment. During interview on 06/23/21 the Administrative Assistant revealed: -The guardian did not sign any paperwork upon	V 113		

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V 113	Continued From page 2 admission. -Several attempts to contact were made and the guardian would not return any phone calls. -The admission packet was mailed to the guardian for signatures and the guardian never returned the information to the facility. During interview on 06/24/21 the Qualified Professional revealed: -The guardian of FC #6 was very difficult to work with. -Several attempts were made to get the admission information completed with the guardian. -The admission packet was mailed to the guardian and she never returned the information to the facility. -FC #6 was at the facility for a very short time.	V 113	V113 Before admission of all new client all required information and documents will be obtained and signed. This will be done according to state regulations as well as Country Pines, Inc policies + Procedure in order to maintain complete client record.	7/8/21
V 114	27G .0207 Emergency Plans and Supplies 10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES (a) A written fire plan for each facility and area-wide disaster plan shall be developed and shall be approved by the appropriate local authority. (b) The plan shall be made available to all staff and evacuation procedures and routes shall be posted in the facility. (c) Fire and disaster drills in a 24-hour facility shall be held at least quarterly and shall be repeated for each shift. Drills shall be conducted under conditions that simulate fire emergencies. (d) Each facility shall have basic first aid supplies accessible for use.	V 114		

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V 114	Continued From page 3 This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to ensure fire and disaster drills were held quarterly and repeated on each shift. The findings are: Review on 06/24/21 of the facility Fire and Disaster drill log from June 2020 thru May 2021 revealed: -During the 2nd quarter (April-June 2021) a date was documented that the fire drills had been completed but no times to indicate the shift the fire drill was completed on. -No documented fire drills for the 4th quarter (October-December 2020). -No documented disaster drills for the 1st quarter (January-March 2021). -During the 2nd quarter a date was documented that the disaster drills had been completed but no times to indicate the shift the disaster drill was completed on. Interviews on 06/23/21 client #3 and client #5 revealed: -They completed fire and disaster drills at the facility. Interview on 06/24/21 the Administrative Assistant revealed: - The facility had 3 shifts. - 1st shift was 8am-3pm. - 2nd shift was 3pm-8pm. - 3rd shift was 8pm-8am. -She would make sure the drills were completed by the staff.	V 114	V114 Country Pines will conduct fire and disaster drills quarterly during each shift as required. Staff will document and complete entire form with results. Drill documention will be posted. Administrative staff will review. 7-8-21	
V 118	27G .0209 (C) Medication Requirements	V 118		

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V 118	Continued From page 4 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 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 MARs current affecting	V 118		

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V 118	Continued From page 5 one of one former client (FC)(#6). The findings are: Review on 06/23/21 of FC #6's record revealed: - 52 year old female. -Admission date of 01/28/21. -Discharge date of 05/18/21. - Diagnoses of Schizoaffective Disorder, Mild Mental Retardation, Hypertension, Chronic Obstructive Pulmonary Disease, Atrial Fibrillation, Diabetes Mellitus-Type 2, Hypothyroidism, Chronic Kidney Disease, Hypogonadism. Review on 06/23/21 of FC #6 FL2 dated 01/26/21 revealed: -Metoprolol ER 25mg Take 1 tablet by mouth at bedtime. -Multaq 400mg Take 1 tablet by mouth twice daily with meals. -Levothyroxine 200mg Take 1 tablet by mouth. -Eliquis 5mg Take 1 tablet by mouth twice daily. -Allergy relief 180mg Take 1 by mouth everyday. -Fluoxetine HCL 40mg Take 1 capsule by mouth everyday. -Furosemide 20mg Take 2 tablets everyday. -Montelukast SOD 10mg Take 1 tablet by mouth everyday. -Vitamin D3 2,000 unit tablet Take 1 tablet by mouth everyday. -Pantoprazole SOD 40mg Take 1 tablet by mouth everyday. -Breo Ellipta 200mcq Inhale 1 puff by mouth everyday. -Spiriva Respimat 1.25mcq Inhale 2 inhalations by mouth everyday. -Lisinopril 2.5mg Take 1 by mouth everyday. Review on 06/23/21 of FC #6's record revealed only 3 MARs and only one of the MARs had FC #6's name and the month of the MARs. The 3	V 118		

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V 118	Continued From page 6 MARs provided had approximately 266 blanks on the MARs. During interview on 06/24/21 the Administrative Assistant revealed: -She did not know why the MARs did not have initials or identifying information. -She did not know where the other MARs for FC #6 were at during the time of the survey. During interview on 06/24/21 the Qualified Professional revealed: -From the time of admission for FC #6 everything was very difficult. -He would ensure in the future a full record was maintained for each client and MARs would be documented accurately. [This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.]	V 118	V118 Country Pines will ensure in the future a full record be maintained for each client and MARS will documented properly to ensure accurate records are Kept. Periodic monitoring will be completed by Administrative Staff of all MARS.	7-8-21
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.	V 536		

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V 536	Continued From page 7 (c) Provider agencies shall establish training based on state competencies, monitor for internal compliance and demonstrate they acted on data gathered. (d) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (e) Formal refresher training must be completed by each service provider periodically (minimum annually). (f) Content of the training that the service provider wishes to employ must be approved by the Division of MH/DD/SAS pursuant to Paragraph (g) of this Rule. (g) Staff shall demonstrate competence in the following core areas: (1) knowledge and understanding of the people being served; (2) recognizing and interpreting human behavior; (3) recognizing the effect of internal and external stressors that may affect people with disabilities; (4) strategies for building positive relationships with persons with disabilities; (5) recognizing cultural, environmental and organizational factors that may affect people with disabilities; (6) recognizing the importance of 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	V 536		

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V 536	Continued From page 8 (9) positive behavioral supports (providing means for people with disabilities to choose activities which directly oppose or replace behaviors which are unsafe). (h) Service providers shall maintain documentation of initial and refresher training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcomes (pass/fail); (B) when and where they attended; and (C) instructor's name; (2) The Division of MH/DD/SAS may review/request this documentation at any time. (i) Instructor Qualifications and Training Requirements: (1) Trainers shall demonstrate competence by scoring 100% on testing in a training program aimed at preventing, reducing and eliminating the need for restrictive interventions. (2) Trainers shall demonstrate competence by scoring a passing grade on testing in an instructor training program. (3) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (4) The content of the instructor training the service provider plans to employ shall be approved by the Division of MH/DD/SAS pursuant to Subparagraph (i)(5) of this Rule. (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	V 536		

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V 536	Continued From page 9 performance; and (D) documentation procedures. (6) Trainers shall have coached experience teaching a training program aimed at preventing, reducing and eliminating the need for restrictive interventions at least one time, with positive review by the coach. (7) Trainers shall teach a training program aimed at preventing, reducing and eliminating the need for restrictive interventions at least once annually. (8) Trainers shall complete a refresher instructor training at least every two years. (j) Service providers shall maintain documentation of initial and refresher instructor training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcomes (pass/fail); (B) when and where attended; and (C) instructor's name. (2) The Division of MH/DD/SAS may request and review this documentation any time. (k) Qualifications of Coaches: (1) Coaches shall meet all preparation requirements as a trainer. (2) Coaches shall teach at least three times the course which is being coached. (3) Coaches shall demonstrate competence by completion of coaching or train-the-trainer instruction. (l) Documentation shall be the same preparation as for trainers.	V 536		

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V 536	Continued From page 10 This Rule is not met as evidenced by: Based on record reviews and interview, the facility failed to ensure 3 of 3 audited staff (#1, #2 and #3) received annual training updates in alternatives to restrictive interventions. The findings are: Review on 06/23/21 of staff #1's personnel record revealed: - Date of Hire: 06/06/19. - Training in alternatives to restrictive interventions expired 01/09/21. Review on 06/23/21 of staff #2 personnel record revealed: - Date of Hire: 09/22/11. - Training in alternatives to restrictive interventions expired 01/09/21. Review on 06/23/21 of staff #3's personnel record revealed: - Date of Hire: 01/2003. - Training in alternatives to restrictive interventions expired 01/09/21. Interview on 06/24/21 the Qualified Professional revealed: -The facility did not use hands on restraints. -All the staff have expired training in alternatives to restrictive interventions. -He was in the process of getting his wife trained to be an instructor. -The would ensure the staff were immediately trained. [This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.]	V 536	V536 Administrative staff to complete training to become staff trainer. All staff will be trained annually. Documentation of training will be placed in staff personnel file	8-23-21

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
MHL096-117 (Y1)	A. Building B. Wing (Y2)	6/24/2021 (Y3)

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY PINES #1	2307 NORTH BESTON ROAD LA GRANGE, NC 28551

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 V0291 Reg. # 27G .5603 LSC	Correction Completed 06/24/2021	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
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REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR Emily Jones, BSW	DATE 6/24/21
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 10/2/2019	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?			☐ YES ☐ NO