Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601417	A. BUILDING: _____ B. WING _____	06/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
QUEEN CITY QUALITY CREW	834 TYVOLA ROAD, SUITE 116 CHARLOTTE, NC 28217

(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 and complaint survey was completed on 6/22/21. The complaint was unsubstantiated (NC #161192). Deficiencies were cited. The facility is licensed for the following service category: 10A NCAC 27G .5400 Day Activity for Individuals of All Disability Groups	V 000	Pls see attached	8.20.21
V 108	27G .0202 (F-I) Personnel Requirements 10A NCAC 27G .0202 PERSONNEL REQUIREMENTS (f) Continuing education shall be documented. (g) Employee training programs shall be provided and, at a minimum, shall consist of the following: (1) general organizational orientation; (2) training on client rights and confidentiality as delineated in 10A NCAC 27C, 27D, 27E, 27F and 10A NCAC 26B; (3) training to meet the mh/dd/sa needs of the client as specified in the treatment/habilitation plan; and (4) training in infectious diseases and bloodborne pathogens. (h) Except as permitted under 10a NCAC 27G .5602(b) of this Subchapter, at least one staff member shall be available in the facility at all times when a client is present. That staff member shall be trained in basic first aid including seizure management, currently trained to provide cardiopulmonary resuscitation and trained in the Heimlich maneuver or other first aid techniques such as those provided by Red Cross, the American Heart Association or their equivalence for relieving airway obstruction. (i) The governing body shall develop and implement policies and procedures for identifying, reporting, investigating and controlling infectious	V 108	Pls see attached DHSR - Mental Health JUL 12 2021 Lic. & Cert. Section	8.20.21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Executive Director — (X6) DATE: 7.09.21

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V 108	Continued From page 1 and communicable diseases of personnel and clients. This Rule is not met as evidenced by: Based on records review and interviews, the facility failed to ensure at least one staff member trained in basic first aid including seizure management, trained to provide cardiopulmonary resuscitation(CPR) and trained in the Heimlich maneuver was available at all times when a client was present for 1 of 3 current staff(#3). The findings are: Review on 6/16/21 of staff #3 personnel record revealed: -hire date of 2/12/18 with the job title of Direct Support Professional; -documentation of completed training in CPR/First Aid dated 2/14/18 with an expiration date of 2/28/20; -no documentation of current recertification of CPR/First Aid present in the record. Interview on 6/22/21 with staff #3 revealed: -worked with client #3 Monday-Friday from a.m.-4 pm; -didn't think that she had CPR/First Aid recertification training; -the office may have it but she didn't have a copy of her updated CPR/First Aid card. Interview on 6/22/21 with client #3 revealed: -go to the park to exercise with staff #3; -volunteers at the church five days a week giving out bag lunches with staff #3;	V 108		

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V 108	Continued From page 2 -goes walking with staff #3 around the whole track; -sometimes they go out to eat at his favorite restaurant sometimes. Interview on 6/17/21 with the Human Resources(HR) staff revealed was not able to locate current CPR/First Aid certification for staff #3. Interview on 6/22/21 with the Director and Program Manager revealed: -had turnover in the HR staff; -will ensure staff #3 is retrained.	V 108		
V 112	27G .0205 (C-D) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (c) The plan shall be developed based on the assessment, and in partnership with the client or legally responsible person or both, within 30 days of admission for clients who are expected to receive services beyond 30 days. (d) The plan shall include: (1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement; (2) strategies; (3) staff responsible; (4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both; (5) basis for evaluation or assessment of outcome achievement; and (6) written consent or agreement by the client or responsible party, or a written statement by the	V 112	PIS see attached	8.20.21

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V 112	Continued From page 3 provider stating why such consent could not be obtained. This Rule is not met as evidenced by: Based on records review and interviews, the facility failed to develop and implement strategies to meet the client's needs affecting 2 of 3 clients(#2, #3). The findings are: Finding #1 Review on 6/17/21 of client #2's record revealed: -admission date of 1/26/21; -diagnoses of Intellectual Developmental Disabilities(IDD)-Mild, Autism, Encephalopathy, Epilepsy, Chronic Kidney Disease Unspecified, Unspecified disorder of binocular vision, myopia, bilateral and regular astigmatism, bilateral; -admission assessment dated 1/28/20 documented client #2 was diagnosed with Mild-IDD, was aggression towards others, took phones, had epilepsy, seizures mostly controlled and liked to stay busy; -Risk/Support Needs Assessment dated 9/22/20 documented client #2 had seizures(grand-mal), required verbal prompts and hand over hand and required 24-hour supervision; -treatment plan dated 1/8/21 documented client #2 transitioned out of institutionalized services into an AFL(Assisted Family Living), Day Supports(DS) Services and CN(Community Networking), had goals for residential services but no documented goals/staff strategies for DS	V 112		

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V 112	Continued From page 4 Services; -Behavioral Support Plan dated 11/1/20 documented client #2 displayed aggressive behaviors, self-injurious behavior and non-compliance. Client #2 was triggered by over stimulation, being told no, waiting, not getting his way, changes in his schedule and being around people smoking or drinking. Interventions included avoid heavy populated areas, give verbal praise, frequent reinforcement of appropriate behaviors, keep busy, provide time for self-expression, redirect behaviors prior to target behaviors, specify clear rules and monitor his behaviors. Interview on 6/17/21 with client #2 revealed: -staff #2 "pick me up in the morning. All kind of places we go to like restaurants, went to the zoo;" -"Cooking, teach me how to cook. Anywhere can learn it at the house, at her house;" -"Exercising. Time people need to lose that weight;" -staff #2 took him to the grocery store; -went to a local amusement park yesterday with staff #2 and walked around. Interview on 6/17/21 with staff #2 revealed: -worked with client #2 for three months; -"before he became AFL, I worked with him in the home;" -"really don't have a goal yet COVID, things been opening back up;" -take client #2 out in the community and to a local recreation center; -"as far as his goals, haven't touched them yet. Work them in next time the manager speak with me;" -client #2 has a Behavior Support Plan; -"he has mild what you call it, have to redirect him, he has mild what is it;"	V 112		

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V 112	Continued From page 5 -"he don't have no behavior." Finding #2: Review on 6/16/21 and 6/17/21 of client #3's record revealed: -admission date of 8/17/17; -diagnoses of IDD-Mild, Unspecified Depressive Disorder, Unspecified Disruptive, Impulse-Control and Conduct Disorder; -admission Assessment dated 11/30/16 and 6/15/17 documented client #3 displayed aggression towards property, was easy to redirect, was sociable, needs to work on his attitude and controlling his anger, had significant mood swings, had lots of anger and frustration. Client #3 also exhibited illusions, limited insight, impaired memory, stealing and frequent lying; -treatment plan dated 8/1/20 and updated 3/12/21 documented client #3 received DS-Individual 25 hours a week until 3/2021 then 14 hours per week with target date of 7/31/21. Client #3's goal for DS-Individual with the target date of 7/31/21: "I will have friends, stay on talks and a meaningful day." -no documented staff strategies for DS goals in the treatment plan. Interview on 6/22/21 with client #3 revealed: -staff #3 is at his house while he does virtual school; -goes to the park to exercise with staff #3; -volunteers at church giving out bag lunches five days a week with staff #3; -goes walking with staff #3 around the whole track; -staff #3 is helping to teach him how to count money and do math; -sometimes they go out to eat and go to his favorite restaurant sometimes; -staff #1 helps him on his goals;	V 112		

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V 112	Continued From page 6 -to stay focused in class and stay on task; -he also says "hi" to his peers; -"That's all I can think of." Interview on 6/22/21 with staff #3 revealed: -She stated that she works with client #3 Mon-Friday from a.m.-p.m.; -his goals that she was working on with client #3 are: stay on task and participate in class, to say hello while out in the community and stay on task while volunteering at the church. Interview on 6/22/21 with the AFL Qualified Professional(QP) revealed: -started here April 5, 2021; -job title was AFL QP; -QP for clients #1, #2 and #3 in their AFLs; -as far as DS go, check in with DS workers on a weekly basis; -discuss client behavioral issues and how can he support; -wasn't advised on anything else to do with DS; -recently advised he will be doing the DS goals; -will be responsible for monitoring the DS goals of the clients; -DS goal sheets that comes along with tasks and staff responsible for that; -not aware of anything in place prior for DS goals progress. Review on 6/21/21 of attachments from an email dated 6/21/21 sent by the Program Manager revealed: -form titled "program goal" for specified service of AFL/Residential/Level 4 with implementation date of 6/23/21 for a community inclusion goal documented client #1 to visit a library twice a month and look for books of interest; -form titled "program goal" for specified service of AFL/Residential/Level 4 with implementation date	V 112		

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V 112	Continued From page 7 of 6/23/21 for a community inclusion/money management goal documented client #2 to visit a restaurant of choice once a month and dine out; -form titled "program goal" for specified service of AFL/Residential/Level 4 with implementation date of 6/23/21 for a money management goal documented client #3 to visit a store twice a month to purchase an item he wants/needs; -none of the forms documented any DS goals for clients #1, #2 and #3. Interview on 6/22/21 with the Director and Program Manager revealed will ensure DS goals and strategies were developed and documented in client treatment plans.	V 112		
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	V 113	Pls see attached	8.20.21

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V 113	Continued From page 8 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; (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 records review and interviews, the facility failed to ensure documentation of progress toward outcomes was present in the client record affecting 3 of 3 clients(#1, #2 and #3). The findings are: Finding #1: Review on 6/16/21 of client #1's record revealed: -admission date of 7/31/19; -diagnoses of Autism, Post Traumatic Stress Disorder(PTSD) and Depressive Disorder; -admission assessment/screening dated 7/3/19 documented client #1 displayed aggression	V 113		

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V 113	Continued From page 9 towards property, was restless, had slow speech, exhibited poor concentration/attention, had impaired judgement, displayed withdrawal and sadness and had loss of interest; -treatment plan dated 11/1/20 and updated 4/1/21 documented Day Support(DS) goal/staff strategies for client #1 as follows: will learn/implement social skills that allow for controlled, appropriate expression of emotions and staff will use reinforcers, calming and coping-incorporate in his schedule to reduce agitation and use a lot of processing if he gets overwhelmed; -no documentation of progress towards DS goal present in the record. Interview on 6/17/21 with client #1 revealed: -worked with staff #1 maybe couple months or a year; -"we walk around mall, have to schedule [local recreation center] or [local amusement park], basically walk or eat;" -walk in stores and look around; -been before to parks "maybe like once;" -work out in community; -work on budget and eating. Interview on 6/17/21 with staff #1 revealed: -began working with client #1 three months go. -work with client #1 Monday through Saturday, sometimes pick him up from work, work around his hours at his job; -go to mall and walk, sightsee and walk in the park; -go and talk with others in park; -mostly walking; -goals-his behaviors, the way he talks and approaches people; -in the am, he has an attitude when she picks him up;	V 113		

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V 113	Continued From page 10 -he gets mad easy. She tells him no, he get mad. He gets upset. She redirects him; -in the am, he did not want to get up; -his attitude can be challenging; -he doesn't want to do anything. Try to redirect him, "this is what we need to do;" -exercise because of his weight; -keep notes on her own; -she and the AFL(Assisted Family Living) home provider talk about it; -current supervisor is the AFL Qualified Professional(QP). -Former Day Program Director was her supervisor; -don't turn in any notes to AFL QP; -asked them for some forms to complete. Finding #2: Review on 6/17/21 of client #2's record revealed: -admission date of 1/26/21; -diagnoses of Intellectual Developmental Disabilities(IDD)-Mild, Autism, Encephalopathy, Epilepsy, Chronic Kidney Disease Unspecified, Unspecified disorder of binocular vision, myopia, bilateral and regular astigmatism, bilateral; -admission assessment dated 1/28/20 documented client #2 was diagnosed with Mild-IDD, was aggressive towards others, took phones, had epilepsy, seizures mostly controlled and liked to stay busy; -Risk/Support Needs Assessment dated 9/22/20 documented client #2 had seizures(grand-mal), required verbal prompts, hand over hand and required 24-hour supervision; -Treatment Plan dated 1/8/21 documented client #2 transitioned out of institutionalized services into an AFL home, DS Services and CN(Community Networking), had goals for residential services but no documented goals/staff strategies for DS Services;	V 113		

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V 113	Continued From page 11 -Behavioral Support Plan dated 11/1/20 documented client #2 displayed aggressive behaviors, self-injurious behavior and non-compliance. Client #2 was triggered by over stimulation, being told no, waiting, not getting his way, changes in his schedule and being around people smoking or drinking. Interventions included avoid heavy populated areas, give verbal praise, frequent reinforcement of appropriate behaviors, keep busy, provide time for self-expression, redirect behaviors prior to target behaviors, specify clear rules and monitor his behaviors; -"Q-note quarterly" DS for March-May 2021: completed by AFL QP dated 6/2/21: calm and enjoys his outings. Has a good working relationship with staff #2 and continues to be active in the community. Engages in trips to the library, local recreation center, local parks, the mall, [local store] and walking. Destinations were limited due to COVID. Behaviorally, client #2 was calm in the community and easily redirected by staff; -no documentation of DS goals and progress completed by staff #2 regarding DS services present in the record. Interview on 6/17/21 with client #2 revealed: -staff #2 "pick me up in the morning. All kind of places we go to like restaurants, went to the zoo;" -"Cooking, teach me how to cook. Anywhere can learn it at the house, at her house;" -"Exercising. Time people need to lose that weight;" -staff #2 took him to the grocery store; -went to local amusement park yesterday with staff #2 and walked around. Interview on 6/17/21 with staff #2 revealed: -worked with client #2 for three months;	V 113		

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V 113	Continued From page 12 -"before he became AFL I worked with him in the home;" -"really don't have a goal yet COVID, things been opening back up;" -take client #2 out in the community and to the YMCA; -"as far as his goals, haven't touched them yet. Work them in next time the manager speak with me;" -"I don't because he has no behavior. Nothing to write about day like." Finding #3: Review on 6/16/21 and 6/17/21 of client #3's record revealed: -admission date of 8/17/17; -diagnoses of IDD-Mild, Unspecified Depressive Disorder, Unspecified Disruptive, Impulse-Control and Conduct Disorder; -admission Assessment dated 11/30/16 and 6/15/17 documented client #3 displayed aggression towards property, was easy to redirect, was sociable, needs to work on his attitude and controlling his anger, had significant mood swings, had lots of anger and frustration. Client #3 also exhibited illusions, limited insight, impaired memory, stealing and frequent lying. -Treatment Plan dated 8/1/20 and updated 3/12/21 documented client #3 received DS-Individual 25 hours a week until 3/2021 then 14 hours per week with target date of 7/31/21. Client #3's goal for DS-Individual with the target date of 7/31/21: "I will have friends, stay on talks and a meaningful day;" -no documentation of progress towards DS goal present in the record. Interview on 6/22/21 with client #3 revealed: -staff #3 is at his house while he does virtual school;	V 113		

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V 113	Continued From page 13 -goes to the park to exercise with staff #3; -volunteers at church giving out bag lunches five days a week with staff #3; -goes walking with staff #3 around the whole track; -staff #3 is helping to teach him how to count money and do math; -sometimes they go out to eat and go to his favorite restaurant sometimes; -staff #1 helps him on his goals; -to stay focused in class and stay on task; -he also says "hi" to his peers; -"That's all I can think of." Interview on 6/22/21 with staff #3 revealed: -works with client #3 Mon-Friday from a.m.-p.m.; -his goals that she was working on with client #3 are: stay on task and participate in class, to say hello while out in the community and stay on task while volunteering at the church; -doesn't do notes; -completes his behavior sheet when he has a behavior; -forwards the behavior sheet to the AFL QP. Interview on 6/22/21 with the AFL Qualified Professional(QP) revealed: -started here April 5, 2021; -job title was AFL QP; -QP for clients #1, #2 and #3 in their AFLs; -as far as DS go, check in with DS workers on a weekly basis; -discuss client behavioral issues and how can he support; -wasn't advised on anything else to do with DS; -recently advised he will be doing the DS goals; -will be responsible for monitoring the DS goals of the clients; -DS goal sheets that comes along with tasks and staff responsible for that;	V 113		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601417	A. BUILDING: _____ B. WING _____	06/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
QUEEN CITY QUALITY CREW	834 TYVOLA ROAD, SUITE 116 CHARLOTTE, NC 28217

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V 113	Continued From page 14 -not aware of anything in place prior for DS goals progress. Interview on 6/22/21 with the Director and Program Manager revealed will ensure documentation of progress towards DS goals will be completed.	V 113		
V 131	G.S. 131E-256 (D2) HCPR - Prior Employment Verification G.S. §131E-256 HEALTH CARE PERSONNEL REGISTRY (d2) Before hiring health care personnel into a health care facility or service, every employer at a health care facility shall access the Health Care Personnel Registry and shall note each incident of access in the appropriate business files. This Rule is not met as evidenced by: Based on records review and interview, the facility failed to ensure the Health Care Personnel Registry (HCPR) was accessed prior to hire for 1 of 3 current staff (#1) and 2 of 3 former staff (FS#4, FS#5). The findings are: Review on 6/16/21 of personnel records revealed: -staff #1 was hired on 10/10/19 with the job title of Direct Support Professional (DSP). There was documentation present in the record the HCPR was accessed on 10/17/19; -former staff #4 was hired on 3/18/19 with the job title of DSP and was transferred to another facility	V 131	Pls see attached	8.20.21

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V 131	Continued From page 15 under the same parent agency in May 2021. There was documentation present in the record the HCPR was accessed on 3/19/19; -former staff #5 was hired on 1/23/19 with the job title of DSP and was terminated on 9/9/20. There was documentation present in the record the HCPR was accessed on 1/24/19. Interview on 6/22/21 with the Director revealed: -have a contracted agency complete the HCPR checks as well as the other checks including the criminal records checks; -not able to access criminal records until prospective staff signs the consent forms at hire; -why HCPR checks were late; -used to have own HR staff complete the HCPR checks; -plan to use own HR staff to complete the HCPR checks prior to hire moving forward.	V 131		
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	V 536	PLS see attached	8.20.21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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V 536	Continued From page 16 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 (9) positive behavioral supports (providing	V 536		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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V 536	Continued From page 17 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 performance; and	V 536		

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V 536	Continued From page 18 (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		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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V 536	Continued From page 19 This Rule is not met as evidenced by: Based on records review and interview, the facility failed to ensure staff completed annual refresher training in alternatives for restrictive interventions for 1 of 3 current staff(#2) and 1 of 3 former staff (FS#5). The findings are: Review on 6/16/21 of personnel records revealed: -staff #2 was hired on 10/30/13 with the job title of Direct Support Professional(DSP). Documentation of completed training in "You're Safe, I'm Safe" dated 8/24/18 with expiration date of 8/31/2019. There was no documentation of completed annual refresher training in "You're Safe, I'm Safe" present in the record; -FS#5 was hired on 1/23/19 with the job title of DSP. Termination date was 9/9/20. Documentation of completed training in "You're Safe, I'm Safe" dated 1/25/19 with expiration date of 1/31/20. There was no documentation of completed annual refresher training in "You're Safe, I'm Safe" present in the record. Interview on 6/17/2 with staff #2 revealed: -been with agency since 2013 or 2014; -had training in "You're Safe, I'm Safe:" -just in December 2020 did "You're Safe I'm Safe;" -renew every year. Attempted interviews with FS#5 on 6/18/21 and 6/21/21 were unsuccessful as the first two attempted phone calls reached a fax number, and the second two attempted phone calls to a second phone number for FS#5 were not answered and no received responses to messages left on the voicemail. Interview on 6/17/21 with Human Resources(HR)	V 536		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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V 536	Continued From page 20 Staff revealed not able to locate the current "You're Safe, I'm Safe" certification for staff #2. Review on 6/21/21 of an email dated 6/21/21 from the Program Manager revealed: -regarding FC#5: "Per review with new HR staff there was no YSIS(Your Safe, I'm Safe) training documented;" -regarding staff #2: "Per review no other documentation was available for YSIS. Staff has been scheduled to attend the next recert(recertification) class on 6/25/2021." Interview on 6/22/21 with the Director and Program Manager revealed: -had turnover in the HR staff; -have staff #2 already scheduled for training.	V 536		
V 537	27E .0108 Client Rights - Training in Sec Rest & ITO 10A NCAC 27E .0108 TRAINING IN SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT (a) Seclusion, physical restraint and isolation time-out may be employed only by staff who have been trained and have demonstrated competence in the proper use of and alternatives to these procedures. Facilities shall ensure that staff authorized to employ and terminate these procedures are retrained and have demonstrated competence at least annually. (b) Prior to providing direct care to people with disabilities whose treatment/habilitation plan includes restrictive interventions, staff including service providers, employees, students or volunteers shall complete training in the use of seclusion, physical restraint and isolation time-out and shall not use these interventions until the	V 537	Pls see attached.	8.2021

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V 537	Continued From page 21 training is completed and competence is demonstrated. (c) A pre-requisite for taking this training is demonstrating competence by completion of training in preventing, reducing and eliminating the need for restrictive interventions. (d) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (e) Formal refresher training must be completed by each service provider periodically (minimum annually). (f) Content of the training that the service provider plans to employ must be approved by the Division of MH/DD/SAS pursuant to Paragraph (g) of this Rule. (g) Acceptable training programs shall include, but are not limited to, presentation of: (1) refresher information on alternatives to the use of restrictive interventions; (2) guidelines on when to intervene (understanding imminent danger to self and others); (3) emphasis on safety and respect for the rights and dignity of all persons involved (using concepts of least restrictive interventions and incremental steps in an intervention); (4) strategies for the safe implementation of restrictive interventions; (5) the use of emergency safety interventions which include continuous assessment and monitoring of the physical and psychological well-being of the client and the safe use of restraint throughout the duration of the restrictive intervention; (6) prohibited procedures;	V 537		

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V 537	Continued From page 22 (7) debriefing strategies, including their importance and purpose; and (8) documentation methods/procedures. (h) Service providers shall maintain documentation of initial and refresher training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcomes (pass/fail); (B) when and where they attended; and (C) instructor's name. (2) The Division of MH/DD/SAS may review/request this documentation at any time. (i) Instructor Qualification and Training Requirements: (1) Trainers shall demonstrate competence by scoring 100% on testing in a training program aimed at preventing, reducing and eliminating the need for restrictive interventions. (2) Trainers shall demonstrate competence by scoring 100% on testing in a training program teaching the use of seclusion, physical restraint and isolation time-out. (3) Trainers shall demonstrate competence by scoring a passing grade on testing in an instructor training program. (4) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (5) The content of the instructor training the service provider plans to employ shall be approved by the Division of MH/DD/SAS pursuant to Subparagraph (j)(6) of this Rule. (6) Acceptable instructor training programs shall include, but not be limited to, presentation of:	V 537		

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V 537	Continued From page 23 (A) understanding the adult learner; (B) methods for teaching content of the course; (C) evaluation of trainee performance; and (D) documentation procedures. (7) Trainers shall be retrained at least annually and demonstrate competence in the use of seclusion, physical restraint and isolation time-out, as specified in Paragraph (a) of this Rule. (8) Trainers shall be currently trained in CPR. (9) Trainers shall have coached experience in teaching the use of restrictive interventions at least two times with a positive review by the coach. (10) Trainers shall teach a program on the use of restrictive interventions at least once annually. (11) Trainers shall complete a refresher instructor training at least every two years. (k) Service providers shall maintain documentation of initial and refresher instructor training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcome (pass/fail); (B) when and where they attended; and (C) instructor's name. (2) The Division of MH/DD/SAS may review/request this documentation at any time. (l) Qualifications of Coaches: (1) Coaches shall meet all preparation requirements as a trainer. (2) Coaches shall teach at least three times, the course which is being coached. (3) Coaches shall demonstrate competence by completion of coaching or train-the-trainer instruction.	V 537		

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V 537	Continued From page 24 (m) Documentation shall be the same preparation as for trainers. This Rule is not met as evidenced by: Based on records review and interview, the facility failed to ensure staff completed annual refresher training annually in restrictive interventions for 1 of 3 current staff(#2) and 1 of 3 former staff (FS#5). The findings are: Based on records review and interview, the facility failed to ensure staff completed annual refresher training in alternatives for restrictive interventions for 1 of 3 current staff(#2) and 1 of 3 former staff (FS#5). The findings are: Review on 6/16/21 of personnel records revealed: -staff #2 was hired on 10/30/13 with the job title of Direct Support Professional(DSP). Documentation of completed training in "You're Safe, I'm Safe" dated 8/24/18 with expiration date of 8/31/2019. There was no documentation of completed annual refresher training in "You're Safe, I'm Safe" present in the record; -FS#5 was hired on 1/23/19 with the job title of DSP. Termination date was 9/9/20. Documentation of completed training in "You're Safe, I'm Safe" dated 1/25/19 with expiration date of 1/31/20. There was no documentation of completed annual refresher training in "You're Safe, I'm Safe" present in the record. Interview on 6/17/2 with staff #2 revealed: -been with agency since 2013 or 2014; -had training in "You're Safe, I'm Safe:" -just in December 2020 did "You're Safe I'm	V 537		

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V 537	Continued From page 25 Safe;" -renew every year. Attempted interviews with FS#5 on 6/18/21 and 6/21/21 were unsuccessful as the first two attempted phone calls reached a fax number, and the second two attempted phone calls to a second phone number for FS#5 were not answered and no received responses to messages left on the voicemail. Interview on 6/17/21 with Human Resources(HR) Staff revealed was not able to locate the current "You're Safe, I'm Safe" certification for staff #2. Review on 6/21/21 of an email dated 6/21/21 from the Program Manager revealed: -regarding FC#5: "Per review with new HR staff there was no YSIS(Your Safe, I'm Safe) training documented;" -regarding staff #2: "Per review no other documentation was available for YSIS. Staff has been scheduled to attend the next recert(recertification) class on 6/25/2021." Interview on 6/22/21 with the Director and Program Manager revealed: -had turnover in the HR staff; -have staff #2 already scheduled for training.	V 537		

Queen City Quality Crew
834 Tyvola Road, Suite 116
Charlotte, NC 28217
Plan of Correction
Date of Survey: 6.22.2021
Provider # MHL0601417

V108 PERSONNEL REQUIREMENTS

The facility will ensure that at least one staff member trained in basic first aid including seizure management, trained to provide cardiopulmonary resuscitation (CPR) and trained in the Heimlich maneuver is present at all times when a client is present.

Staff #3 has been retrained in CPR/First Aid.
The Qualified Professional will utilize a training tracking tool to track training. Said tool will be reviewed monthly and reminders will be sent out to staff 60 days prior to expiration of training.

At least monthly, the Program Manager or Quality Assurance Manager will review a random sample of training files to ensure that required training is current.

To be completed by: 8/20/2021
Person(s) responsible: Qualified Professional, Program Manager, Quality Assurance Manager.

V112 ASSESMENT/TREATMENT/HABILITATION OR SERVICE PLAN

The facility will develop and implement strategies to meet the client's needs, specifically clients #2 and #3.

Day Support program goals will be developed and implemented for clients #2 and #3. The Qualified Professional will train the providers relative to the goals and will monitor progress monthly.

The Program Manager or Quality Assurance Manager will review a random sample of AFL files monthly to ensure that day support goals and strategies are developed and documented in client's treatment plans.

To be completed by: 8/20/2021
Person(s) responsible: Qualified Professional, Program Manager, Quality Assurance Manager.

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V 113 CLIENT RECORDS

Client records will be maintained for each individual admitted to the facility.
The facility will ensure documentation of progress toward outcomes is present in the client records, specifically for clients #1, #2, and #3.
The Qualified Professional will train the providers relative to the day support goals and will supply said providers with the forms to document day support goals for clients #1, #2, and #3. The Qualified Professional will document progress monthly on the day support goals. The Program Manager or Qualified Professional will audit a random sample of files monthly to ensure implementation and documentation of day support goals is completed.

To be completed by: 8/20/2021
Person(s) responsible: Qualified Professional, Program Manager, Quality Assurance Manager.

V 131 HEALTHCARE PERSONNEL REGISTRY

The facility will ensure that the Health Care Personnel Registry is accessed prior to hire for all staff.
The Executive Director will train the Qualified Professional and the Human Resources support staff relative to the requirement of the Health Care Personnel Registry completion prior to hire.
The Human Resource staff or Program Manager will audit the files prior to hire to ensure that the Health Care Personnel Registry is accessed prior to hire.

To be completed by: 8/20/2021
Person(s) responsible: Qualified Professional, Program Manager, Quality Assurance Manager.

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V 536 TRAINING ON ALTERNATIVES TO RESTRICTIVE INTERVENTIONS
The facility will ensure that staff complete annual refresher training in alternatives for restrictive interventions, specifically for staff #2.

Staff #2 received the annual refresher training on 6.25.21 in alternatives for restrictive interventions.

At least monthly, the Program Manager or Quality Assurance Manager will review a random sample of training files to ensure that required training is current.

To be completed by: 8/20/2021
Person(s) responsible: Qualified Professional, Program Manager, Quality Assurance Manager.

V 537 TRAINING IN SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME OUT
The facility will ensure staff complete annual refresher training in restrictive interventions, specifically for staff #2.

Staff #2 received the annual refresher training on 6.25.21 in restrictive interventions.

At least monthly, the Program Manager or Quality Assurance Manager will review a random sample of training files to ensure that required training is current.

To be completed by: 8/20/2021
Person(s) responsible: Qualified Professional, Program Manager, Quality Assurance Manager.

COMMUNITY ALTERNATIVES OF NORTH CAROLINA
A RESCARE COMMUNITY LIVING AGENCY

818 Tyvola Road, Suite 104
Charlotte, NC 28217

July 9, 2021

Gina McLain
Facility Compliance Consultant I
Mental Health Licensure and Certification Section
NC Division of Health Service Regulation
2718 Mail Service Center
Raleigh, NC 27699-2718

Re: Plan of Correction for Survey Conducted June 22, 2021
Educare Community Living Corporation – NC Queen City Quality Crew
834 Tyvola Road, Suite 116, Charlotte, NC 28217
Provider Number: MHL0601417

Dear Mrs. McLain.

Thank you for your time and the feedback given during the survey you completed on June 22nd, 2021. We appreciate your diligence in assisting us in providing the best care possible to the consumers we serve. We look forward to making the recommended changes that will improve the services we provide.

Enclosed you will the Plan of Correction which is already in process. If you have any questions, please call me at 704.777.9830. Again, thank you for your time and patience.

Sincerely,

Denise Derkowski
Executive Director, CANC - Charlotte

Enclosures