

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL082-056	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 07/19/2021
--	---	---	---

NAME OF PROVIDER OR SUPPLIER CANDII HOMES	STREET ADDRESS, CITY, STATE, ZIP CODE 404 EAST POWELL STREET CLINTON, NC 28328
---	--

(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	<p>INITIAL COMMENTS</p> <p>A complaint and limited follow up survey for the Type A1 rule violation was completed on July 19, 2021. The complaint was unsubstantiated (intake # NC00179117). This was a limited follow up survey, only 10A NCAC 27G .5601 Scope (v289); 10A NCAC 27G .0202 Personnel Requirements (v108); 10A NCAC 27G .0205 Assessment and Treatment/Habilitation or Service Plan (v112); 122C-8 Criminal History Record Check (v133); 10A NCAC 27G .0604 Incident Reporting Requirements for Category A and B Providers (v367); 10A NCAC 27G .0107 Training on Alternatives to Restrictive Interventions (v536); and 10A NCAC 27G .0108 Training in Seclusion, Physical Restraint and Isolation Time Out (v537) were reviewed for compliance. The following were brought back into compliance: 10A NCAC 27G .0205 Assessment and Treatment/Habilitation or Service Plan (v111); 10A NCAC 27G .0209 Medication Requirements (v118); and 10A NCAC 27G .0603 Incident Response Requirements for Category A and B Providers (v366). Deficiencies were cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities.</p>	V 000		
V 105	<p>27G .0201 (A) (1-7) Governing Body Policies</p> <p>10A NCAC 27G .0201 GOVERNING BODY POLICIES</p> <p>(a) The governing body responsible for each facility or service shall develop and implement written policies for the following:</p> <p>(1) delegation of management authority for the operation of the facility and services;</p> <p>(2) criteria for admission;</p> <p>(3) criteria for discharge;</p>	V 105		

Division of Health Service Regulation LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
--	-------	-----------

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL082-056	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 07/19/2021
--	---	---	---

NAME OF PROVIDER OR SUPPLIER CANDII HOMES	STREET ADDRESS, CITY, STATE, ZIP CODE 404 EAST POWELL STREET CLINTON, NC 28328
---	--

(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 105	<p>Continued From page 1</p> <p>(4) admission assessments, including: (A) who will perform the assessment; and (B) time frames for completing assessment.</p> <p>(5) client record management, including: (A) persons authorized to document; (B) transporting records; (C) safeguard of records against loss, tampering, defacement or use by unauthorized persons; (D) assurance of record accessibility to authorized users at all times; and (E) assurance of confidentiality of records.</p> <p>(6) screenings, which shall include: (A) an assessment of the individual's presenting problem or need; (B) an assessment of whether or not the facility can provide services to address the individual's needs; and (C) the disposition, including referrals and recommendations;</p> <p>(7) quality assurance and quality improvement activities, including: (A) composition and activities of a quality assurance and quality improvement committee; (B) written quality assurance and quality improvement plan; (C) methods for monitoring and evaluating the quality and appropriateness of client care, including delineation of client outcomes and utilization of services; (D) professional or clinical supervision, including a requirement that staff who are not qualified professionals and provide direct client services shall be supervised by a qualified professional in that area of service; (E) strategies for improving client care; (F) review of staff qualifications and a determination made to grant treatment/habilitation privileges; (G) review of all fatalities of active clients who</p>	V 105		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL082-056	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 07/19/2021
--	---	---	---

NAME OF PROVIDER OR SUPPLIER CANDII HOMES	STREET ADDRESS, CITY, STATE, ZIP CODE 404 EAST POWELL STREET CLINTON, NC 28328
---	--

(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 105	<p>Continued From page 2</p> <p>were being served in area-operated or contracted residential programs at the time of death; (H) adoption of standards that assure operational and programmatic performance meeting applicable standards of practice. For this purpose, "applicable standards of practice" means a level of competence established with reference to the prevailing and accepted methods, and the degree of knowledge, skill and care exercised by other practitioners in the field;</p> <p>This Rule is not met as evidenced by: Based on record review and interview the facility failed to develop and implement adoption of standards that assure operational and programmatic performance meeting applicable standards of practice for the use of a Glucometer instrument including the CLIA (Clinical Laboratory Improvement Amendments) waiver. The findings are:</p> <p>Review on 7/14/21 of client #2's record revealed:</p> <ul style="list-style-type: none"> - 44-year-old admitted 3/13/17. - Diagnoses included Intellectual/Developmental Disability, mild; Schizoaffective Disorder, bipolar type, and "Diebetic." - FL-2 dated 1/25/21 included finger stick blood sugar checks twice daily, 2 hours before breakfast and 2 hours after supper. - Documentation that client #2's blood sugar was checked twice daily as ordered. 	V 105		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL082-056	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 07/19/2021
--	---	---	---

NAME OF PROVIDER OR SUPPLIER CANDII HOMES	STREET ADDRESS, CITY, STATE, ZIP CODE 404 EAST POWELL STREET CLINTON, NC 28328
---	--

(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 105	Continued From page 3 During interview on 7/19/21 client #2 stated staff checked her blood sugar twice daily. During interview on 7/19/21 the Administrator/Licensee stated staff checked client #2's blood sugar twice daily as ordered. She was unaware of the requirement for the facility to have a CLIA certificate. The Registered Nurse/Qualified Professional did not tell her of the requirement. She would obtain a CLIA certificate for the facility.	V 105		
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	V 108		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL082-056	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 07/19/2021
--	---	---	---

NAME OF PROVIDER OR SUPPLIER CANDII HOMES	STREET ADDRESS, CITY, STATE, ZIP CODE 404 EAST POWELL STREET CLINTON, NC 28328
---	--

(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 108	<p>Continued From page 4</p> <p>equivalence for relieving airway obstruction. (i) The governing body shall develop and implement policies and procedures for identifying, reporting, investigating and controlling infectious and communicable diseases of personnel and clients.</p> <p>This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to ensure that 4 of 6 audited staff (#1, #2, #4, and #6) received training to meet the needs of the clients. The findings are:</p> <p>Review on 7/15/21 of staff #1's personnel record revealed: - No hire date, title paraprofessional. - No documentation of training in mental health diagnoses, elopement behaviors, aggressive/assaultive behaviors to meet the needs of the clients.</p> <p>Review on 7/15/21 of staff #2's personnel record revealed: - No hire date, title of paraprofessional. - No documentation of training in mental health diagnoses, elopement behaviors, aggressive/assaultive behaviors to meet the needs of the clients.</p> <p>Review on 7/15/21 of staff #4's personnel record revealed: - No hire date, title of paraprofessional. - No documentation of training in developmental disabilities, mental health diagnoses, elopement behaviors, aggressive/assaultive behaviors to</p>	V 108		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL082-056	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 07/19/2021
--	---	---	---

NAME OF PROVIDER OR SUPPLIER CANDII HOMES	STREET ADDRESS, CITY, STATE, ZIP CODE 404 EAST POWELL STREET CLINTON, NC 28328
---	--

(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 108	<p>Continued From page 5</p> <p>meet the needs of the clients.</p> <p>During interview on 7/16/21 staff #4 stated:</p> <ul style="list-style-type: none"> - She worked 1:1 with client #3 for 3 hours in the afternoon, Monday thru Friday. - Her responsibilities when working 1:1 with client #3 were to make sure he didn't get hurt, and to help him cross the street safely. - Client #3 had not attempted to elope since she began working with him, but he would try to hit others and he did it to be funny. <p>Review on 7/15/21 of staff #6's personnel record revealed:</p> <ul style="list-style-type: none"> - No hire date, title of paraprofessional. - No documentation of training in mental health diagnoses, elopement behaviors, aggressive/assaultive behaviors to meet the needs of the clients. <p>During interviews on 7/15/21 and 7/19/21 the Administrator/Licensee stated:</p> <ul style="list-style-type: none"> - Staff #1 was hired 5/10/18. - Staff #2 was hired 12/12/19. - Staff #4 was hired 5/05/21. - Staff #6 was hired 3/17/21. - Staff were trained to meet the needs of the clients; staff training included diabetes management, medication administration, incident reporting and developmental disabilities. - The Acting Qualified Professional/Consultant/Trainer did staff training. - "All this has happened because I don't have a QP." <p>This deficiency constitutes a re-cited deficiency and must be corrected within 23 days.</p> <p>This deficiency is cross referenced into 10A NCAC 27G .5601 SCOPE (v289) for a Continued</p>	V 108		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL082-056	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 07/19/2021
--	---	---	---

NAME OF PROVIDER OR SUPPLIER CANDII HOMES	STREET ADDRESS, CITY, STATE, ZIP CODE 404 EAST POWELL STREET CLINTON, NC 28328
---	--

(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 108	Continued From page 6 Failure to Correct Type A1 rule violation.	V 108		
V 110	27G .0204 Training/Supervision Paraprofessionals 10A NCAC 27G .0204 COMPETENCIES AND SUPERVISION OF PARAPROFESSIONALS (a) There shall be no privileging requirements for paraprofessionals. (b) Paraprofessionals shall be supervised by an associate professional or by a qualified professional as specified in Rule .0104 of this Subchapter. (c) Paraprofessionals shall demonstrate knowledge, skills and abilities required by the population served. (d) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence. (e) Competence shall be demonstrated by exhibiting core skills including: (1) technical knowledge; (2) cultural awareness; (3) analytical skills; (4) decision-making; (5) interpersonal skills; (6) communication skills; and (7) clinical skills. (f) The governing body for each facility shall develop and implement policies and procedures for the initiation of the individualized supervision plan upon hiring each paraprofessional.	V 110		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL082-056	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 07/19/2021
--	---	---	---

NAME OF PROVIDER OR SUPPLIER CANDII HOMES	STREET ADDRESS, CITY, STATE, ZIP CODE 404 EAST POWELL STREET CLINTON, NC 28328
---	--

(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 110	<p>Continued From page 7</p> <p>This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to ensure paraprofessionals were supervised by an Associate Professional (AP) or by a Qualified Professional (QP). The findings are:</p> <p>Review on 7/14/21 of the Division of Health Service Regulation (DHSR) Client Census and Staff Form completed by the Administrator/Licensee revealed one current Registered Nurse/Qualified Professional (RN/QP) and one current Acting QP/Consultant/Trainer.</p> <p>Review on 7/14/21 of the RN/QP's personnel record revealed neither a date of hire nor a date of separation.</p> <p>During interview on 7/15/21 the RN/QP stated:</p> <ul style="list-style-type: none"> - She last worked at the facility over a month ago. - She was the QP and did staff training. - She attended virtual meetings regarding the clients and gave advice. - She was not permitted to do the work necessary. - She was denied entry into the facility "due to COVID." - She was told another QP was providing services at the facility and that she was no longer needed. <p>Review on 7/15/21 of the Acting QP/Consultant/Trainer's record revealed:</p> <ul style="list-style-type: none"> - A binder with invoices for staff training. - No personnel record. <p>During interview on 7/15/21 the Acting QP/Consultant/Trainer stated:</p> <ul style="list-style-type: none"> - She was a QP Consultant. - She provided staff training but did not supervise 	V 110		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL082-056	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 07/19/2021
--	---	---	---

NAME OF PROVIDER OR SUPPLIER CANDII HOMES	STREET ADDRESS, CITY, STATE, ZIP CODE 404 EAST POWELL STREET CLINTON, NC 28328
---	--

(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 110	<p>Continued From page 8</p> <p>facility staff.</p> <ul style="list-style-type: none"> - She was not employed at the facility, nor did she have a contract with the Administrator/Licensee. - She had not observed the clients, nor had she attended any client meetings. - The Administrator/Licensee would meet with the clients and their guardians, write the treatment plans and send the information to her to be typed. - She would type the plans as the Administrator/Licensee wrote them but she did not sign them and was not responsible for their implementation. - She was not on the Administrator/Licensee's payroll and did not have a job description. - The Administrator/Licensee had been trying to hire a QP for some time. - One of the facility staff might be interested in the position of QP, but she wasn't sure if that person met requirements to be a QP. <p>During interviews on 7/14/21, 7/15/21, and 7/19/21 the Administrator/Licensee stated:</p> <ul style="list-style-type: none"> - The RN/QP was originally hired in 2012 and was re-hired 3/18/20. - The RN/QP last provided services for the facility in May 2021. - "She sent me the last training she did, she invoiced me for the work she completed. I called her again when you came in and she did not respond and that was it." - The RN/QP "separated herself " at the onset of the current survey. - The Acting QP/Consultant/Trainer was the Acting QP, she was a Consultant QP. - The Acting QP/Consultant/Trainer was going to train someone to assume the role of the QP. - The Acting QP/Consultant/Trainer had "been with us for a while;" she assisted with staff training, plans of correction and implementing changes at the facility. 	V 110		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL082-056	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 07/19/2021
--	---	---	---

NAME OF PROVIDER OR SUPPLIER CANDII HOMES	STREET ADDRESS, CITY, STATE, ZIP CODE 404 EAST POWELL STREET CLINTON, NC 28328
---	--

(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 110	<p>Continued From page 9</p> <ul style="list-style-type: none"> - The Acting QP/Consultant/Trainer's job description was to consult with staff regarding incident reports and to help with clients' treatment/habilitation plans. - She told staff to call the Acting QP/Consultant/Trainer if they had questions. - No QP was employed at the facility. - "All this has happened because I don't have a QP." - She had taken measures to recruit and hire a QP, but "no one in this area wants to be a QP." - She was neither an Associate Professional (AP) nor a QP. - Staff supervision was supposed to be provided by an AP or QP. - She could not "run the agency" without a QP. <p>This deficiency is cross referenced into 10A NCAC 27G .5601 SCOPE (v289) for a Failure to Correct Type A1 rule violation</p>	V 110		
V 112	<p>27G .0205 (C-D) Assessment/Treatment/Habilitation Plan</p> <p>10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN</p> <p>(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.</p> <p>(d) The plan shall include:</p> <ol style="list-style-type: none"> (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 	V 112		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL082-056	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 07/19/2021
--	---	---	---

NAME OF PROVIDER OR SUPPLIER CANDII HOMES	STREET ADDRESS, CITY, STATE, ZIP CODE 404 EAST POWELL STREET CLINTON, NC 28328
---	--

(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 112	<p>Continued From page 10</p> <p>annually in consultation with the client or legally responsible person or both;</p> <p>(5) basis for evaluation or assessment of outcome achievement; and</p> <p>(6) written consent or agreement by the client or responsible party, or a written statement by the provider stating why such consent could not be obtained.</p> <p>This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to develop and implement goals and strategies for 2 of 3 audited clients (client #2 and client #3). The findings are:</p> <p>Review on 7/14/21 of client #2's record revealed:</p> <ul style="list-style-type: none"> - 44-year-old admitted 3/13/17. - Diagnoses included Intellectual/Developmental Disability, mild; Schizoaffective Disorder, bipolar type, and "diebetic." - FL-2 signed 1/25/21 included ". . . Patient Information . . . Bladder . . . incontinent bed wetting . . .," finger stick blood sugar checks twice daily and Metformin (treats diabetes) 500 mg 1 tablet twice daily with breakfast and dinner. - "Individual Support Plan (ISP) Short Range Goals" with implementation date of 5/1/21 with no short range goals to address management of diabetes or nighttime incontinence; no strategies for residential staff to follow; and no client, Guardian or Qualified Professional signatures. 	V 112		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL082-056	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 07/19/2021
--	---	---	---

NAME OF PROVIDER OR SUPPLIER CANDII HOMES	STREET ADDRESS, CITY, STATE, ZIP CODE 404 EAST POWELL STREET CLINTON, NC 28328
---	--

(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 112	<p>Continued From page 11</p> <p>During interview on 7/19/21 client #2 stated one of her goals was to be patient about getting her cigarettes and to be nice when talking with others.</p> <p>Review on 7/14/21 of client #3's record revealed: - 24 year old admitted 11/02/17. - Diagnoses included Autism Spectrum Disorder, moderate; Post Traumatic Stress Disorder; unspecified Schizophrenia; and selective mutism. - "Update to Individual Support Plan" from the Local Management Entity dated of 3/15/21 included: ". . . What is happening in my life right now? . . . [Client #3] has refused to attend most medical appointments in the past. . . What needs to change? [Client #3] is no longer allowed out in the community without supervision due to him staying out past his designated time frames. [Client #3] has demonstrated inappropriate behaviors of being intoxicated, meeting with others in the community, walking in high crime areas, dressing inappropriate when in community putting his health and safety in jeopardy. LRP (Legally Responsible Person) is in agreement with this decision. . . . [Client #3] has a history of dumpster diving for food, acting suspicious in stores for possible theft. (Law enforcement being called). Crossing the street unsafe. [Client #3] needs a one on one primary support male staff to support him in receiving more consistency, structure and assist him in learning to develop a bond related to his gender identification role. [Client #3] has a history of eloping out of his bedroom window and has disabled his window alarm on several occassions. . . Goal 5 [Client #3] will increase his independent living skills . . . Supported to urinate in appropriate places . . . will not lock himself in his bathroom. . . " - "Individual Support Plan Short Range Goals" with implementation date of 3/15/21 included a</p>	V 112		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL082-056	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 07/19/2021
--	---	---	---

NAME OF PROVIDER OR SUPPLIER CANDII HOMES	STREET ADDRESS, CITY, STATE, ZIP CODE 404 EAST POWELL STREET CLINTON, NC 28328
---	--

(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 112	<p>Continued From page 12</p> <p>short range goal for unsupervised time in the community for 30 minutes Monday - Friday and up to 2 hours on Saturday and Sunday; no short range goals to address unsafe behaviors, urinating in appropriate places or locking himself in the bathroom; no strategies for residential staff to follow and no client, Guardian or QP signatures.</p> <p>During interview on 7/19/21 client #3 stated he would like to be able to go out on his own.</p> <p>During interview on 7/19/21 the Administrator/Licensee stated: - Client #3 did not have unsupervised time in the home or community; he had 1:1 staff in the home and in the community. - The RN/QP was supposed to revise the Individual Support Plan Short Range Goals for clients #2 and #3 to include goals to meet identified needs and strategies for staff to follow when training the goals. - "She (RN/QP) didn't do what she was supposed to do. I gave you what she sent."</p> <p>This deficiency constitutes a re-cited deficiency and must be corrected within 23 days.</p> <p>This deficiency is cross referenced into 10A NCAC 27G .5601 SCOPE (v289) for a Continued Failure to Correct Type A1 rule violation</p>	V 112		
V 133	<p>G.S. 122C-80 Criminal History Record Check</p> <p>G.S. §122C-80 CRIMINAL HISTORY RECORD CHECK REQUIRED FOR CERTAIN APPLICANTS FOR EMPLOYMENT. (a) Definition. - As used in this section, the term "provider" applies to an area authority/county</p>	V 133		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL082-056	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 07/19/2021
--	---	---	---

NAME OF PROVIDER OR SUPPLIER CANDII HOMES	STREET ADDRESS, CITY, STATE, ZIP CODE 404 EAST POWELL STREET CLINTON, NC 28328
---	--

(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 133	Continued From page 13 program and any provider of mental health, developmental disability, and substance abuse services that is licensable under Article 2 of this Chapter. (b) Requirement. - An offer of employment by a provider licensed under this Chapter to an applicant to fill a position that does not require the applicant to have an occupational license is conditioned on consent to a State and national criminal history record check of the applicant. If the applicant has been a resident of this State for less than five years, then the offer of employment is conditioned on consent to a State and national criminal history record check of the applicant. The national criminal history record check shall include a check of the applicant's fingerprints. If the applicant has been a resident of this State for five years or more, then the offer is conditioned on consent to a State criminal history record check of the applicant. A provider shall not employ an applicant who refuses to consent to a criminal history record check required by this section. Except as otherwise provided in this subsection, within five business days of making the conditional offer of employment, a provider shall submit a request to the Department of Justice under G.S. 114-19.10 to conduct a criminal history record check required by this section or shall submit a request to a private entity to conduct a State criminal history record check required by this section. Notwithstanding G.S. 114-19.10, the Department of Justice shall return the results of national criminal history record checks for employment positions not covered by Public Law 105-277 to the Department of Health and Human Services, Criminal Records Check Unit. Within five business days of receipt of the national criminal history of the person, the Department of Health	V 133		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL082-056	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 07/19/2021
--	---	---	---

NAME OF PROVIDER OR SUPPLIER CANDII HOMES	STREET ADDRESS, CITY, STATE, ZIP CODE 404 EAST POWELL STREET CLINTON, NC 28328
---	--

(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 133	<p>Continued From page 14</p> <p>and Human Services, Criminal Records Check Unit, shall notify the provider as to whether the information received may affect the employability of the applicant. In no case shall the results of the national criminal history record check be shared with the provider. Providers shall make available upon request verification that a criminal history check has been completed on any staff covered by this section. A county that has adopted an appropriate local ordinance and has access to the Division of Criminal Information data bank may conduct on behalf of a provider a State criminal history record check required by this section without the provider having to submit a request to the Department of Justice. In such a case, the county shall commence with the State criminal history record check required by this section within five business days of the conditional offer of employment by the provider. All criminal history information received by the provider is confidential and may not be disclosed, except to the applicant as provided in subsection (c) of this section. For purposes of this subsection, the term "private entity" means a business regularly engaged in conducting criminal history record checks utilizing public records obtained from a State agency.</p> <p>(c) Action. - If an applicant's criminal history record check reveals one or more convictions of a relevant offense, the provider shall consider all of the following factors in determining whether to hire the applicant:</p> <ol style="list-style-type: none"> (1) The level and seriousness of the crime. (2) The date of the crime. (3) The age of the person at the time of the conviction. (4) The circumstances surrounding the commission of the crime, if known. (5) The nexus between the criminal conduct of 	V 133		
-------	---	-------	--	--

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL082-056	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 07/19/2021
--	---	---	---

NAME OF PROVIDER OR SUPPLIER CANDII HOMES	STREET ADDRESS, CITY, STATE, ZIP CODE 404 EAST POWELL STREET CLINTON, NC 28328
---	--

(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 133	<p>Continued From page 15</p> <p>the person and the job duties of the position to be filled.</p> <p>(6) The prison, jail, probation, parole, rehabilitation, and employment records of the person since the date the crime was committed.</p> <p>(7) The subsequent commission by the person of a relevant offense.</p> <p>The fact of conviction of a relevant offense alone shall not be a bar to employment; however, the listed factors shall be considered by the provider. If the provider disqualifies an applicant after consideration of the relevant factors, then the provider may disclose information contained in the criminal history record check that is relevant to the disqualification, but may not provide a copy of the criminal history record check to the applicant.</p> <p>(d) Limited Immunity. - A provider and an officer or employee of a provider that, in good faith, complies with this section shall be immune from civil liability for:</p> <p>(1) The failure of the provider to employ an individual on the basis of information provided in the criminal history record check of the individual.</p> <p>(2) Failure to check an employee's history of criminal offenses if the employee's criminal history record check is requested and received in compliance with this section.</p> <p>(e) Relevant Offense. - As used in this section, "relevant offense" means a county, state, or federal criminal history of conviction or pending indictment of a crime, whether a misdemeanor or felony, that bears upon an individual's fitness to have responsibility for the safety and well-being of persons needing mental health, developmental disabilities, or substance abuse services. These crimes include the criminal offenses set forth in any of the following Articles of Chapter 14 of the General Statutes: Article 5, Counterfeiting and</p>	V 133		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL082-056	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 07/19/2021
--	---	---	---

NAME OF PROVIDER OR SUPPLIER CANDII HOMES	STREET ADDRESS, CITY, STATE, ZIP CODE 404 EAST POWELL STREET CLINTON, NC 28328
---	--

(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 133	<p>Continued From page 16</p> <p>Issuing Monetary Substitutes; Article 5A, Endangering Executive and Legislative Officers; Article 6, Homicide; Article 7A, Rape and Other Sex Offenses; Article 8, Assaults; Article 10, Kidnapping and Abduction; Article 13, Malicious Injury or Damage by Use of Explosive or Incendiary Device or Material; Article 14, Burglary and Other Housebreakings; Article 15, Arson and Other Burnings; Article 16, Larceny; Article 17, Robbery; Article 18, Embezzlement; Article 19, False Pretenses and Cheats; Article 19A, Obtaining Property or Services by False or Fraudulent Use of Credit Device or Other Means; Article 19B, Financial Transaction Card Crime Act; Article 20, Frauds; Article 21, Forgery; Article 26, Offenses Against Public Morality and Decency; Article 26A, Adult Establishments; Article 27, Prostitution; Article 28, Perjury; Article 29, Bribery; Article 31, Misconduct in Public Office; Article 35, Offenses Against the Public Peace; Article 36A, Riots and Civil Disorders; Article 39, Protection of Minors; Article 40, Protection of the Family; Article 59, Public Intoxication; and Article 60, Computer-Related Crime. These crimes also include possession or sale of drugs in violation of the North Carolina Controlled Substances Act, Article 5 of Chapter 90 of the General Statutes, and alcohol-related offenses such as sale to underage persons in violation of G.S. 18B-302 or driving while impaired in violation of G.S. 20-138.1 through G.S. 20-138.5.</p> <p>(f) Penalty for Furnishing False Information. - Any applicant for employment who willfully furnishes, supplies, or otherwise gives false information on an employment application that is the basis for a criminal history record check under this section shall be guilty of a Class A1 misdemeanor.</p> <p>(g) Conditional Employment. - A provider may</p>	V 133		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL082-056	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 07/19/2021
--	---	---	---

NAME OF PROVIDER OR SUPPLIER CANDII HOMES	STREET ADDRESS, CITY, STATE, ZIP CODE 404 EAST POWELL STREET CLINTON, NC 28328
---	--

(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 133	<p>Continued From page 17</p> <p>employ an applicant conditionally prior to obtaining the results of a criminal history record check regarding the applicant if both of the following requirements are met:</p> <p>(1) The provider shall not employ an applicant prior to obtaining the applicant's consent for criminal history record check as required in subsection (b) of this section or the completed fingerprint cards as required in G.S. 114-19.10.</p> <p>(2) The provider shall submit the request for a criminal history record check not later than five business days after the individual begins conditional employment. (2000-154, s. 4; 2001-155, s. 1; 2004-124, ss. 10.19D(c), (h); 2005-4, ss. 1, 2, 3, 4, 5(a); 2007-444, s. 3.)</p> <p>This Rule is not met as evidenced by: Based on record reviews and interview the facility failed to request a state criminal background check within five business days of employment for 1 of 5 audited staff (#7). The findings are:</p> <p>Review on 7/15/21 of staff #7's personnel record revealed:</p> <ul style="list-style-type: none"> - Hire date 7/07/21, title of Paraprofessional. - State criminal background check dated 5/18/20. - No documentation of consent for an updated criminal background check. <p>During interview on 7/19/21 the Licensee's Biller (office staff) stated:</p> <ul style="list-style-type: none"> - She sent off some criminal background check requests recently. - She did not know where staff #7's criminal background check was; it was not in her 	V 133		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL082-056	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 07/19/2021
--	---	---	---

NAME OF PROVIDER OR SUPPLIER CANDII HOMES	STREET ADDRESS, CITY, STATE, ZIP CODE 404 EAST POWELL STREET CLINTON, NC 28328
---	--

(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 133	<p>Continued From page 18</p> <p>personnel record.</p> <p>During interviews on 7/15/21 and 7/19/21 the Administrator/Licensee stated:</p> <ul style="list-style-type: none"> - A criminal background check for staff #7 was done in 2020. - She did not know a new criminal background check was required if someone was re-hired. - Staff #7 was "just brought back" to work as needed for coverage. - Staff #7 was re-hired on 7/08/21 and she worked the weekend of 7/10/21 - 7/11/21. - Staff #7 "came back" on 7/08/21 and left; staff #7 told the Administrator/Licensee she would not return. - "She's not thinking about coming back. If she does, I'll have to do her book all over again." <p>This deficiency constitutes a re-cited deficiency and must be corrected within 23 days.</p> <p>This deficiency is cross referenced into 10A NCAC 27G .5601 SCOPE (v289) for a Continued Failure to Correct Type A1 rule violation.</p>	V 133		
V 289	<p>27G .5601 Supervised Living - Scope</p> <p>10A NCAC 27G .5601 SCOPE</p> <p>(a) Supervised living is a 24-hour facility which provides residential services to individuals in a home environment where the primary purpose of these services is the care, habilitation or rehabilitation of individuals who have a mental illness, a developmental disability or disabilities, or a substance abuse disorder, and who require supervision when in the residence.</p> <p>(b) A supervised living facility shall be licensed if the facility serves either:</p> <p>(1) one or more minor clients; or</p>	V 289		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL082-056	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 07/19/2021
--	---	---	---

NAME OF PROVIDER OR SUPPLIER CANDII HOMES	STREET ADDRESS, CITY, STATE, ZIP CODE 404 EAST POWELL STREET CLINTON, NC 28328
---	--

(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 289	<p>Continued From page 19</p> <p>(2) two or more adult clients. Minor and adult clients shall not reside in the same facility.</p> <p>(c) Each supervised living facility shall be licensed to serve a specific population as designated below:</p> <p>(1) "A" designation means a facility which serves adults whose primary diagnosis is mental illness but may also have other diagnoses;</p> <p>(2) "B" designation means a facility which serves minors whose primary diagnosis is a developmental disability but may also have other diagnoses;</p> <p>(3) "C" designation means a facility which serves adults whose primary diagnosis is a developmental disability but may also have other diagnoses;</p> <p>(4) "D" designation means a facility which serves minors whose primary diagnosis is substance abuse dependency but may also have other diagnoses;</p> <p>(5) "E" designation means a facility which serves adults whose primary diagnosis is substance abuse dependency but may also have other diagnoses; or</p> <p>(6) "F" designation means a facility in a private residence, which serves no more than three adult clients whose primary diagnoses is mental illness but may also have other disabilities, or three adult clients or three minor clients whose primary diagnoses is developmental disabilities but may also have other disabilities who live with a family and the family provides the service. This facility shall be exempt from the following rules: 10A NCAC 27G .0201 (a)(1),(2),(3),(4),(5)(A)&(B); (6); (7) (A),(B),(E),(F),(G),(H); (8); (11); (13); (15); (16); (18) and (b); 10A NCAC 27G .0202(a),(d),(g)(1) (i); 10A NCAC 27G .0203; 10A NCAC 27G .0205</p>	V 289		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL082-056	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 07/19/2021
--	---	---	---

NAME OF PROVIDER OR SUPPLIER CANDII HOMES	STREET ADDRESS, CITY, STATE, ZIP CODE 404 EAST POWELL STREET CLINTON, NC 28328
---	--

(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 289	<p>Continued From page 20</p> <p>(a),(b); 10A NCAC 27G .0207 (b),(c); 10A NCAC 27G .0208 (b),(e); 10A NCAC 27G .0209[(c)(1) - non-prescription medications only] (d)(2),(4); (e) (1)(A),(D),(E);(f);(g); and 10A NCAC 27G .0304 (b)(2),(d)(4). This facility shall also be known as alternative family living or assisted family living (AFL).</p> <p>This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure care and habilitation designed to meet the needs of the individuals affecting 2 of 3 audited clients (#2 and #3). The findings are</p> <p>A. Cross Reference: 10A NCAC 27G .0202 PERSONNEL REQUIREMENTS (v108). Based on record reviews and interviews the facility failed to ensure that 4 of 5 audited staff (#1, #2, #4, and #6) received training to meet the needs of the clients.</p> <p>B. Cross Reference: 10A NCAC 27G .0204 COMPETENCIES AND SUPERVISION OF PARAPROFESSIONALS (v110). Based on record reviews and interviews the facility failed to ensure paraprofessionals were supervised by an associate professional or by a qualified professional.</p> <p>C. Cross Reference: 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (v112). Based on record reviews and interviews the facility failed to develop and implement goals strategies for 2 of 3 audited</p>	V 289		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL082-056	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 07/19/2021
--	---	---	---

NAME OF PROVIDER OR SUPPLIER CANDII HOMES	STREET ADDRESS, CITY, STATE, ZIP CODE 404 EAST POWELL STREET CLINTON, NC 28328
---	--

(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 289	<p>Continued From page 21</p> <p>clients (client #2 and client #3).</p> <p>D. Cross Reference: G.S §122C-80 CRIMINAL HISTORY RECORD CHECK REQUIRED FOR CERTAIN APPLICANTS FOR EMPLOYMENT (v133). Based on record reviews and interview the facility failed to request a state criminal background check within five business days of employment for 1 of 5 audited staff (#7).</p> <p>E. Cross Reference: 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND CATEGORY B PROVIDERS (v367). Based on record reviews and interviews the facility failed to complete a Level II incident report.</p> <p>F. Cross Reference: 10A NCAC 27G .0107 TRAINING ON ALTERNATIVES TO RESTRICTIVE INTERVENTIONS (v536). Based on record review and interview the facility failed to ensure 1 of 5 audited staff (#7) received annual training update in alternatives to restrictive interventions prior to providing services.</p> <p>G. Cross Reference 10A NCAC 27G .0108 TRAINING IN SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT (v537). Based on record review and interview the facility failed to ensure 1 of 5 staff (#7) received annual training update in seclusion, physical restraint and isolation time out.</p> <p>Review on 7/19/21 of the Plan of Protection dated 7/19/21 and completed by the Administrator/Licensee revealed: - "What immediate action will the facility take to ensure the safety of the consumers in your care? I will hire a competent Qualified Professional as soon as I can find one. Personnel requirements-</p>	V 289		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL082-056	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 07/19/2021
--	---	---	---

NAME OF PROVIDER OR SUPPLIER CANDII HOMES	STREET ADDRESS, CITY, STATE, ZIP CODE 404 EAST POWELL STREET CLINTON, NC 28328
---	--

(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 289	<p>Continued From page 22</p> <p>I will continue to monitor on the monthly basis- Staff shall receive training on Alternatives restricted intervention- incident reporting- training in seclusion and physical restraint and isolation and time out- the agency shall revised all employees training to better deliverd the services in this facility."</p> <p>- "Describe your plans to make sure the above happens 1. Find a qualified professional for supervision of paraprofessional 2. Revise the personnel requirements 3. Revise the Assessment and treatment plans 4. Continue to check criminal record on the monthly basis 5. Continue to train staff on Alternative to restricted interventions 6. Training in seclusion physical restraint and isolation time out in other to protect residents the agency will continue to work hard on these issues."</p> <p>Clients #2 and #3 had diagnoses which included mild Intellectual/Developmental Disorder, Schizoaffective Disorder, Bipolar type, Diabetes, compulsive liar, Autism Spectrum Disorder (moderate), Post Traumatic Stress Disorder, and Unspecified Schizophrenia. Behaviors exhibited by the client #3 included elopement, aggression, and threats to others. These behaviors and mental health diagnoses were not addressed through the provision of staff training or the development and implementation strategies. Client #2 had diagnoses of diabetes and nighttime bed-wetting, yet no goals or strategies to address these conditions were developed and implemented. Client #3's unsupervised time was recently discontinued due to unsafe behaviors when in the community, however, his treatment plan was not updated to reflect the change in supervision level. The systemic failures of the facility included the failure to develop and implement goals and strategies and provide staff</p>	V 289		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL082-056	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 07/19/2021
--	---	---	---

NAME OF PROVIDER OR SUPPLIER CANDII HOMES	STREET ADDRESS, CITY, STATE, ZIP CODE 404 EAST POWELL STREET CLINTON, NC 28328
---	--

(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 289	Continued From page 23 training to address behaviors and medical needs of the clients, report incidents as required, including implementing corrective actions. Additionally, there was systemic failure to ensure training in the use of alternatives to restrictive interventions and the use of seclusion, physical restraint and isolation time out prior to the delivery of services and the completion of a criminal record check for staff (#7). The facility also failed to hire a Qualified Professional to provide staff supervision. The failure of the facility to establish systems to correct previous deficiencies and prior Type A1 violation constitutes a Failure to Correct the Type A1 rule violation originally cited for serious neglect. An administrative penalty of \$500.00 per day is imposed for failure to correct within 23 days.	V 289		
V 367	27G .0604 Incident Reporting Requirements 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall report all level II incidents, except deaths, that occur during the provision of billable services or while the consumer is on the providers premises or level III incidents and level II deaths involving the clients to whom the provider rendered any service within 90 days prior to the incident to the LME responsible for the catchment area where services are provided within 72 hours of becoming aware of the incident. The report shall be submitted on a form provided by the Secretary. The report may be submitted via mail, in person, facsimile or encrypted electronic means. The report shall include the following information: (1) reporting provider contact and	V 367		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL082-056	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 07/19/2021
--	---	---	---

NAME OF PROVIDER OR SUPPLIER CANDII HOMES	STREET ADDRESS, CITY, STATE, ZIP CODE 404 EAST POWELL STREET CLINTON, NC 28328
---	--

(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 367	<p>Continued From page 24</p> <p>identification information;</p> <p>(2) client identification information;</p> <p>(3) type of incident;</p> <p>(4) description of incident;</p> <p>(5) status of the effort to determine the cause of the incident; and</p> <p>(6) other individuals or authorities notified or responding.</p> <p>(b) Category A and B providers shall explain any missing or incomplete information. The provider shall submit an updated report to all required report recipients by the end of the next business day whenever:</p> <p>(1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or</p> <p>(2) the provider obtains information required on the incident form that was previously unavailable.</p> <p>(c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including:</p> <p>(1) hospital records including confidential information;</p> <p>(2) reports by other authorities; and</p> <p>(3) the provider's response to the incident.</p> <p>(d) Category A and B providers shall send a copy of all level III incident reports to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of becoming aware of the incident. Category A providers shall send a copy of all level III incidents involving a client death to the Division of Health Service Regulation within 72 hours of becoming aware of the incident. In cases of client death within seven days of use of seclusion or restraint, the provider shall report the death immediately, as required by 10A NCAC 26C .0300 and 10A NCAC 27E .0104(e)(18).</p>	V 367		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL082-056	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 07/19/2021
--	---	---	---

NAME OF PROVIDER OR SUPPLIER CANDII HOMES	STREET ADDRESS, CITY, STATE, ZIP CODE 404 EAST POWELL STREET CLINTON, NC 28328
---	--

(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 367	<p>Continued From page 25</p> <p>(e) Category A and B providers shall send a report quarterly to the LME responsible for the catchment area where services are provided. The report shall be submitted on a form provided by the Secretary via electronic means and shall include summary information as follows:</p> <ol style="list-style-type: none"> (1) medication errors that do not meet the definition of a level II or level III incident; (2) restrictive interventions that do not meet the definition of a level II or level III incident; (3) searches of a client or his living area; (4) seizures of client property or property in the possession of a client; (5) the total number of level II and level III incidents that occurred; and (6) a statement indicating that there have been no reportable incidents whenever no incidents have occurred during the quarter that meet any of the criteria as set forth in Paragraphs (a) and (d) of this Rule and Subparagraphs (1) through (4) of this Paragraph. <p>This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to complete a Level II incident report within 72 hours of becoming aware of the incident as required. The findings are:</p> <p>Review on 7/14/21 of the North Carolina Incident Response Improvement System (IRIS) revealed: - No level II report regarding client #3's incident of elopement to his day program at 7:30 am on 4/28/21.</p>	V 367		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL082-056	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 07/19/2021
--	---	---	---

NAME OF PROVIDER OR SUPPLIER CANDII HOMES	STREET ADDRESS, CITY, STATE, ZIP CODE 404 EAST POWELL STREET CLINTON, NC 28328
---	--

(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 367	<p>Continued From page 26</p> <ul style="list-style-type: none"> - No level II report regarding former client #5 refusing medications, approaching others in and aggressive manner and threatening staff #2 resulting contact with the local police and former client #5's involuntary commitment and subsequent discharge from the facility. <p>During interviews on 7/14/21 and 7/19/21 the Administrator/Licensee stated:</p> <ul style="list-style-type: none"> - There had been no level II incidents at the facility since the annual, complaint, and follow-up survey completed on 5/13/21. - She did not remember completing an incident report for former client #5. - "He was having behavioral issues and he refused medications from his psychiatrist, he said he wanted to go to the hospital, so he went to the hospital." - An attempt to enter an incident report for former client #5 into IRIS was made, but the system did not accept the information submitted. - "He was not getting any type of residential support. They wanted to know what type of support he was getting, I couldn't put anything there." - "The residents over here don't receive Innovations, IPRS (Integrated Payment and Reporting System) funding or any other service, so when you try to put it into IRIS they stop you from continuing from putting that information in." - "I think I'll do the paper ones and send them in the mail." - All staff were trained in incident reporting. - The Registered Nurse/Qualified Professional told her an incident report was not necessary unless the police or fire department were called. <p>This deficiency constitutes a re-cited deficiency and must be corrected within 23 days.</p>	V 367		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL082-056	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 07/19/2021
--	---	---	---

NAME OF PROVIDER OR SUPPLIER CANDII HOMES	STREET ADDRESS, CITY, STATE, ZIP CODE 404 EAST POWELL STREET CLINTON, NC 28328
---	--

(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 367	Continued From page 27 This deficiency is cross referenced into 10A NCAC 27G .5601 SCOPE (v289) for a Continued Failure to Correct Type A1 rule violation.	V 367		
V 536	27E .0107 Client Rights - Training on Alt to Rest. Int. 10A NCAC 27E .0107 TRAINING ON ALTERNATIVES TO RESTRICTIVE INTERVENTIONS (a) Facilities shall implement policies and practices that emphasize the use of alternatives to restrictive interventions. (b) Prior to providing services to people with disabilities, staff including service providers, employees, students or volunteers, shall demonstrate competence by successfully completing training in communication skills and other strategies for creating an environment in which the likelihood of imminent danger of abuse or injury to a person with disabilities or others or property damage is prevented. (c) Provider agencies shall establish training based on state competencies, monitor for internal compliance and demonstrate they acted on data gathered. (d) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (e) Formal refresher training must be completed by each service provider periodically (minimum annually). (f) Content of the training that the service provider wishes to employ must be approved by the Division of MH/DD/SAS pursuant to Paragraph (g) of this Rule.	V 536		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL082-056	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 07/19/2021
--	---	---	---

NAME OF PROVIDER OR SUPPLIER CANDII HOMES	STREET ADDRESS, CITY, STATE, ZIP CODE 404 EAST POWELL STREET CLINTON, NC 28328
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 536	<p>Continued From page 28</p> <p>(g) Staff shall demonstrate competence in the following core areas:</p> <ul style="list-style-type: none"> (1) knowledge and understanding of the people being served; (2) recognizing and interpreting human behavior; (3) recognizing the effect of internal and external stressors that may affect people with disabilities; (4) strategies for building positive relationships with persons with disabilities; (5) recognizing cultural, environmental and organizational factors that may affect people with disabilities; (6) recognizing the importance of and assisting in the person's involvement in making decisions about their life; (7) skills in assessing individual risk for escalating behavior; (8) communication strategies for defusing and de-escalating potentially dangerous behavior; and (9) positive behavioral supports (providing means for people with disabilities to choose activities which directly oppose or replace behaviors which are unsafe). <p>(h) Service providers shall maintain documentation of initial and refresher training for at least three years.</p> <ul style="list-style-type: none"> (1) Documentation shall include: <ul style="list-style-type: none"> (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. <p>(i) Instructor Qualifications and Training Requirements:</p> <ul style="list-style-type: none"> (1) Trainers shall demonstrate competence 	V 536		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL082-056	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 07/19/2021
--	---	---	---

NAME OF PROVIDER OR SUPPLIER CANDII HOMES	STREET ADDRESS, CITY, STATE, ZIP CODE 404 EAST POWELL STREET CLINTON, NC 28328
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 536	<p>Continued From page 29</p> <p>by scoring 100% on testing in a training program aimed at preventing, reducing and eliminating the need for restrictive interventions.</p> <p>(2) Trainers shall demonstrate competence by scoring a passing grade on testing in an instructor training program.</p> <p>(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.</p> <p>(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.</p> <p>(5) Acceptable instructor training programs shall include but are not limited to presentation of:</p> <p>(A) understanding the adult learner;</p> <p>(B) methods for teaching content of the course;</p> <p>(C) methods for evaluating trainee performance; and</p> <p>(D) documentation procedures.</p> <p>(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.</p> <p>(7) Trainers shall teach a training program aimed at preventing, reducing and eliminating the need for restrictive interventions at least once annually.</p> <p>(8) Trainers shall complete a refresher instructor training at least every two years.</p> <p>(j) Service providers shall maintain documentation of initial and refresher instructor training for at least three years.</p> <p>(1) Documentation shall include:</p>	V 536		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL082-056	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 07/19/2021
--	---	---	---

NAME OF PROVIDER OR SUPPLIER CANDII HOMES	STREET ADDRESS, CITY, STATE, ZIP CODE 404 EAST POWELL STREET CLINTON, NC 28328
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 536	<p>Continued From page 30</p> <p>(A) who participated in the training and the outcomes (pass/fail);</p> <p>(B) when and where attended; and</p> <p>(C) instructor's name.</p> <p>(2) The Division of MH/DD/SAS may request and review this documentation any time.</p> <p>(k) Qualifications of Coaches:</p> <p>(1) Coaches shall meet all preparation requirements as a trainer.</p> <p>(2) Coaches shall teach at least three times the course which is being coached.</p> <p>(3) Coaches shall demonstrate competence by completion of coaching or train-the-trainer instruction.</p> <p>(l) Documentation shall be the same preparation as for trainers.</p> <p> </p> <p>This Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure 1 of 5 audited staff (#7) received annual training update in alternatives to restrictive interventions prior to providing services. The findings are:</p> <ul style="list-style-type: none"> - Review on 7/15/21 of staff #7's personnel record revealed: - Hire date 7/07/21, title of Paraprofessional. - NCI+ (North Carolina Interventions) Restrictive (Preventions, Defensive, Restrictive) training dated 7/08/20, expired 7/07/21. - No updated NCI+ training. <p>During interviews on 7/15/21 and 7/19/21 the</p>	V 536		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL082-056	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 07/19/2021
--	---	---	---

NAME OF PROVIDER OR SUPPLIER CANDII HOMES	STREET ADDRESS, CITY, STATE, ZIP CODE 404 EAST POWELL STREET CLINTON, NC 28328
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 536	<p>Continued From page 31</p> <p>Administrator/Licensee stated:</p> <ul style="list-style-type: none"> - Staff #7 was "just brought back" to work as needed for coverage. - Staff #7 was re-hired on 7/08/21 and she worked the weekend of 7/10/21 - 7/11/21. - Staff #7 "came back" on 7/08/21 and left; staff #7 told the Administrator/Licensee she would not return. - Staff #7 only worked one day, 7/08/21. - "She's not thinking about coming back. If she does, I'll have to do her book all over again." <p>This deficiency constitutes a re-cited deficiency and must be corrected within 23 days.</p> <p>This deficiency is cross referenced into 10A NCAC 27G .5601 SCOPE (v289) for a Continued Failure to Correct Type A1 rule violation.</p>	V 536		
V 537	<p>27E .0108 Client Rights - Training in Sec Rest & ITO</p> <p>10A NCAC 27E .0108 TRAINING IN SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT</p> <p>(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.</p> <p>(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</p>	V 537		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL082-056	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 07/19/2021
--	---	---	---

NAME OF PROVIDER OR SUPPLIER CANDII HOMES	STREET ADDRESS, CITY, STATE, ZIP CODE 404 EAST POWELL STREET CLINTON, NC 28328
---	--

(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	<p>Continued From page 32</p> <p>and shall not use these interventions until the training is completed and competence is demonstrated.</p> <p>(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.</p> <p>(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.</p> <p>(e) Formal refresher training must be completed by each service provider periodically (minimum annually).</p> <p>(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.</p> <p>(g) Acceptable training programs shall include, but are not limited to, presentation of:</p> <ol style="list-style-type: none"> (1) refresher information on alternatives to the use of restrictive interventions; (2) guidelines on when to intervene (understanding imminent danger to self and others); (3) emphasis on safety and respect for the rights and dignity of all persons involved (using concepts of least restrictive interventions and incremental steps in an intervention); (4) strategies for the safe implementation of restrictive interventions; (5) the use of emergency safety interventions which include continuous assessment and monitoring of the physical and psychological well-being of the client and the safe use of restraint throughout the duration of the restrictive intervention; 	V 537		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL082-056	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 07/19/2021
--	---	---	---

NAME OF PROVIDER OR SUPPLIER CANDII HOMES	STREET ADDRESS, CITY, STATE, ZIP CODE 404 EAST POWELL STREET CLINTON, NC 28328
---	--

(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	<p>Continued From page 33</p> <p>(6) prohibited procedures;</p> <p>(7) debriefing strategies, including their importance and purpose; and</p> <p>(8) documentation methods/procedures.</p> <p>(h) Service providers shall maintain documentation of initial and refresher training for at least three years.</p> <p>(1) Documentation shall include:</p> <p>(A) who participated in the training and the outcomes (pass/fail);</p> <p>(B) when and where they attended; and</p> <p>(C) instructor's name.</p> <p>(2) The Division of MH/DD/SAS may review/request this documentation at any time.</p> <p>(i) Instructor Qualification and Training Requirements:</p> <p>(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.</p> <p>(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.</p> <p>(3) Trainers shall demonstrate competence by scoring a passing grade on testing in an instructor training program.</p> <p>(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.</p> <p>(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.</p> <p>(6) Acceptable instructor training programs shall include, but not be limited to, presentation</p>	V 537		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL082-056	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 07/19/2021
--	---	---	---

NAME OF PROVIDER OR SUPPLIER CANDII HOMES	STREET ADDRESS, CITY, STATE, ZIP CODE 404 EAST POWELL STREET CLINTON, NC 28328
---	--

(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	<p>Continued From page 34</p> <p>of:</p> <p>(A) understanding the adult learner;</p> <p>(B) methods for teaching content of the course;</p> <p>(C) evaluation of trainee performance; and</p> <p>(D) documentation procedures.</p> <p>(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.</p> <p>(8) Trainers shall be currently trained in CPR.</p> <p>(9) Trainers shall have coached experience in teaching the use of restrictive interventions at least two times with a positive review by the coach.</p> <p>(10) Trainers shall teach a program on the use of restrictive interventions at least once annually.</p> <p>(11) Trainers shall complete a refresher instructor training at least every two years.</p> <p>(k) Service providers shall maintain documentation of initial and refresher instructor training for at least three years.</p> <p>(1) Documentation shall include:</p> <p>(A) who participated in the training and the outcome (pass/fail);</p> <p>(B) when and where they attended; and</p> <p>(C) instructor's name.</p> <p>(2) The Division of MH/DD/SAS may review/request this documentation at any time.</p> <p>(l) Qualifications of Coaches:</p> <p>(1) Coaches shall meet all preparation requirements as a trainer.</p> <p>(2) Coaches shall teach at least three times, the course which is being coached.</p> <p>(3) Coaches shall demonstrate competence by completion of coaching or</p>	V 537		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL082-056	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 07/19/2021
--	---	---	---

NAME OF PROVIDER OR SUPPLIER CANDII HOMES	STREET ADDRESS, CITY, STATE, ZIP CODE 404 EAST POWELL STREET CLINTON, NC 28328
---	--

(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	<p>Continued From page 35</p> <p>train-the-trainer instruction. (m) Documentation shall be the same preparation as for trainers.</p> <p>This Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure 1 of 5 staff (#7) received annual training update in seclusion, physical restraint and isolation time out. The findings are:</p> <p>Review on 7/15/21 of staff #7's personnel record revealed:</p> <ul style="list-style-type: none"> - Hire date 7/07/21, title of Paraprofessional. - NCI+ (North Carolina Interventions) Restrictive (Preventions, Defensive, Restrictive) training dated 7/08/20, expired 7/07/21. - No updated NCI+ training. <p>During interviews on 7/15/21 and 7/19/21 the Administrator/Licensee stated:</p> <ul style="list-style-type: none"> - Staff #7 was "just brought back" to work as needed for coverage. - Staff #7 was re-hired on 7/08/21 and she worked the weekend of 7/10/21 - 7/11/21. - Staff #7 "came back" on 7/08/21 and left; staff #7 told the Administrator/Licensee she would not return. - Staff #7 only worked one day, 7/08/21. - "She's not thinking about coming back. If she does, I'll have to do her book all over again." <p>This deficiency constitutes a re-cited deficiency and must be corrected within 23 days.</p> <p>This deficiency is cross referenced into 10A NCAC 27G .5601 SCOPE (v289) for a Continued</p>	V 537		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL082-056	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 07/19/2021
--	---	---	---

NAME OF PROVIDER OR SUPPLIER CANDII HOMES	STREET ADDRESS, CITY, STATE, ZIP CODE 404 EAST POWELL STREET CLINTON, NC 28328
---	--

(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	Continued From page 36 Failure to Correct Type A1 rule violation.	V 537		