STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL068-159	A. BUILDING: _____ B. WING _____	R 08/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLSBOROUGH RECOVERY SOLUTIONS	129 MAYO STREET HILLSBOROUGH, NC 27278

(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 follow-up survey was completed on August 13, 2021. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .3600 Outpatient Opioid Treatment. The client census was 135 at the time of the survey.	V 000		
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	V 108		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL068-159	A. BUILDING: _____ B. WING _____	R 08/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLSBOROUGH RECOVERY SOLUTIONS	129 MAYO STREET HILLSBOROUGH, NC 27278

(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 1 implement policies and procedures for identifying, reporting, investigating and controlling infectious and communicable diseases of personnel and clients. This Rule is not met as evidenced by: Based on record reviews, observation and interviews, the facility failed to ensure that at least one staff on duty had training in Cardiopulmonary Resuscitation (Lead Nurse). The findings are: Review on 8/13/21 of Lead Nurse's personnel record revealed: -She was hired on 8/27/17.. -She was hired as a Nurse. -Certification of Cardiopulmonary Resuscitation expired on March 2020. Observation on 8/11/21 at 9:15 am of the facility revealed: -Only three center staff and a contractor were working at the time. -None of the staff that were working at the time had an updated training in Cardiopulmonary Resuscitation. Interview on 8/13/21 with the Lead Nurse revealed: -She was the only nurse working on 8/11/21. -She knew that her training on Cardiopulmonary Resuscitation had expired. -She knew that her co-worker had her Cardiopulmonary Resuscitation certification up to date and the both of them normally worked together.	V 108		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL068-159	A. BUILDING: _____ B. WING _____	R 08/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLSBOROUGH RECOVERY SOLUTIONS	129 MAYO STREET HILLSBOROUGH, NC 27278

(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 2 -She was aware that only one staff on duty needed to have updated training in Cardiopulmonary Resuscitation. -She acknowledged that there were times that she was the only nurse working. -She acknowledged that on 8/11/21, she was the only nurse on duty and there were no other staff working that had an updated training on Cardiopulmonary Resuscitation. Interview on 8/13/21 with the Program Director revealed: -She was not aware that the Lead Nurse's certification of Cardiopulmonary Resuscitation had expired. -She was aware that only one staff on duty needed to have training on Cardiopulmonary Resuscitation. -She had been informed that other staff at the facility did not need to have certification on Cardiopulmonary Resuscitation, but she believed that it would be best practice if everyone had the training completed. -She would have the Lead Nurse and other staff at the facility enroll for training on Cardiopulmonary Resuscitation. -She acknowledged that on 8/11/21, there were no staff working that had an updated training on Cardiopulmonary Resuscitation.	V 108		
V 235	27G .3603 (A-C) Outpt. Opiod Tx. - Staff 10A NCAC 27G .3603 STAFF (a) A minimum of one certified drug abuse counselor or certified substance abuse counselor to each 50 clients and increment thereof shall be on the staff of the facility. If the facility falls below this prescribed ratio, and is unable to employ an individual who is certified because of the	V 235		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL068-159	A. BUILDING: _____ B. WING _____	R 08/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLSBOROUGH RECOVERY SOLUTIONS	129 MAYO STREET HILLSBOROUGH, NC 27278

(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 235	Continued From page 3 unavailability of certified persons in the facility's hiring area, then it may employ an uncertified person, provided that this employee meets the certification requirements within a maximum of 26 months from the date of employment. (b) Each facility shall have at least one staff member on duty trained in the following areas: (1) drug abuse withdrawal symptoms; and (2) symptoms of secondary complications to drug addiction. (c) Each direct care staff member shall receive continuing education to include understanding of the following: (1) nature of addiction; (2) the withdrawal syndrome; (3) group and family therapy; and (4) infectious diseases including HIV, sexually transmitted diseases and TB. This Rule is not met as evidenced by: Based on record reviews and interview, the facility failed to ensure each direct care staff member received continuing education in nature of addiction and the withdrawal syndrome affecting two of five audited staff (Lead Nurse, Program Director). The findings are: Review on 8/13/21 of the Lead Nurse's personnel file revealed: -She was hired on 8/27/17. -She was hired as a Nurse. -She had no documentation of continuing education in nature of addiction and the withdrawal syndrome. Review on 8/13/21 of the Program Director's	V 235		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL068-159	A. BUILDING: _____ B. WING _____	R 08/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLSBOROUGH RECOVERY SOLUTIONS	129 MAYO STREET HILLSBOROUGH, NC 27278

(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 235	Continued From page 4 personnel file revealed: -She was hired on 5/30/18.. -She was hired as a Counselor. -She was promoted as the Program Director on September 2019. -She had no documentation of continuing education in nature of addiction and the withdrawal syndrome. Interview on 8/13/21 with the Lead Nurse and the Program Director revealed: -Agency had been bought by another group and had been re-organized. -Agency used RELIAS in the past as training program for staff, but stopped after it was sold. They had no way of getting access to all of their past trainings which included nature of addictions as well as withdrawal syndrome. -Program Director had been promoted and she was not informed of deficiencies that had to be corrected from the last state's survey completed in 2019. -They confirmed they had no continuing education in nature of addiction and the withdrawal syndrome on their file. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 235		
V 237	27G .3604 (A-D) Outpt. Opiod - Operations 10A NCAC 27G .3604 OPERATIONS (a) Hours. Each facility shall operate at least six days per week, 12 months per year. Daily, weekend and holiday medication dispensing hours shall be scheduled to meet the needs of the client. (b) Compliance with The Substance Abuse and Mental Health Services Administration (SAMHSA)	V 237		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL068-159	A. BUILDING: _____ B. WING _____	R 08/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLSBOROUGH RECOVERY SOLUTIONS	129 MAYO STREET HILLSBOROUGH, NC 27278

(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 237	Continued From page 5 or The Center for Substance Abuse Treatment (CSAT) Regulations. Each facility shall be certified by a private non-profit entity or a State agency, that has been approved by the SAMHSA of the United State Department of Health and Human Services and shall be in compliance with all SAMHSA Opioid Drugs in Maintenance and Detoxification Treatment of Opioid Addiction regulations in 42 CFR Part 8, which are incorporated by reference to include subsequent amendments and editions. These regulations are available from the CSAT, SAMHSA, Rockwall II, 5600 Fishers Lane, Rockville, Maryland 20857 at no cost. (c) Compliance With DEA Regulations. Each facility shall be currently registered with the Federal Drug Enforcement Administration and shall be in compliance with all Drug Enforcement Administration regulations pertaining to opioid treatment programs codified in 21 C.F.R., Food and Drugs, Part 1300 to end, which are incorporated by reference to include subsequent amendments and editions. These regulations are available from the United States Government Printing Office, Washington, D.C. 20402 at the published rate. (d) Compliance With State Authority Regulations. Each facility shall be approved by the North Carolina State Authority for Opioid Treatment, DMH/DD/SAS, which is the person designated by the Secretary of Health and Human Services to exercise the responsibility and authority within the state for governing the treatment of addiction with an opioid drug, including program approval, for monitoring compliance with the regulations related to scope, staff, and operations, and for monitoring compliance with Section 1923 of P.L. 102-321. The referenced material may be obtained from the Substance Abuse Services	V 237		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL068-159	A. BUILDING: _____ B. WING _____	R 08/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLSBOROUGH RECOVERY SOLUTIONS	129 MAYO STREET HILLSBOROUGH, NC 27278

(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 237	Continued From page 6 Section of DMH/DD/SAS. This Rule is not met as evidenced by: Based on interview and records review, the facility management failed to ensure program compliance in the area of Individual Counseling requirements affecting 6 of 13 current audited clients (#1, #2, #3, #4, #5 and #6). The findings are: Review on 8/13/21 of the North Carolina State Opioid Treatment Authorities (SOTA) program requirements revealed the following information; -- Individual Counseling requirements: "During the first year of continuous treatment each client attended a minimum of two counseling sessions per month, and after the first year of treatment attended at least one counseling session per month." Review on 8/12/21 of Client #1's record revealed: -Admission date of 5/1/17. -Diagnosis of Opioid Use Disorder, Severe. -Last presented for dosing on 8/10/21, dosed with 175 milligrams (mg) of Methadone. -Last documented face to face contact with a counselor was on 6/1/21. Review on 8/12/21 of Client #2's record revealed: -Admission date of 5/20/21. -Diagnosis of Opioid Use Disorder, Severe on Maintenance. -Had tested positive for illegal substances on 6/10/21, 7/2/21 and 7/15/21. -Last presented for dosing on 7/20/21, dosed with 4 mg of Methadone. -Last documented face to face contact with a counselor was on 6/2/21.	V 237		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL068-159	A. BUILDING: _____ B. WING _____	R 08/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLSBOROUGH RECOVERY SOLUTIONS	129 MAYO STREET HILLSBOROUGH, NC 27278

(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 237	Continued From page 7 Review on 8/12/21 of Client #3's record revealed: -Admission date of 3/27/18.. -Diagnosis of Opioid Use Disorder, Severe on Maintenance. -Had tested positive for illegal substances on 6/2/21, 6/23/21, 7/8/21, 7/19/21. -Last presented for dosing on 8/1/21, dosed with 40 mg of Methadone. -Last documented face to face contact with a counselor was on 5/28/21. Review on 8/12/21 of Client #4's record revealed: -Admission date of 11/12/19. -Diagnosis of Opioid Use Disorder, Severe on Maintenance. -Had tested positive for illegal substances on 6/4/21, 6/25/21, 7/2/21, 7/16/21. -Last presented for dosing on 8/11/21, dosed with 105 mg of Methadone. -Last documented face to face contact with a counselor was on 5/26/21. Review on 8/12/21 of Client #5's record revealed: -Admission date of 4/25/17. -Diagnosis of Opioid Use Disorder, Severe on Maintenance. -Had tested positive for illegal substances and alcohol on 6/8/21, 7/1/21, 7/8/21, 7/20/21, 7/29/21. -Last presented for dosing on 8/12/21, dosed with 68 mg of Methadone. -Last documented face to face contact with a counselor was on 5/26/21. Review on 8/12/21 of Client #3's record revealed: -Admission date of 4/6/21. -Diagnosis of Opioid Use Disorder, Severe on Maintenance. -Had tested positive for illegal substances on	V 237		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL068-159	A. BUILDING: _____ B. WING _____	R 08/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLSBOROUGH RECOVERY SOLUTIONS	129 MAYO STREET HILLSBOROUGH, NC 27278

(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 237	Continued From page 8 5/10/21, 5/14/21, 5/24/21, 6/8/21, 6/18/21, 7/9/21. -Last presented for dosing on 8/11/21, dosed with 80 mg of Methadone. -There was documented counseling sessions for 4/21/21, 6/16/21, 7/7/21, 7/13/21, 8/9/21. -There was no documentation of a face to face counseling session for the month of May 2021 and only one session for the month of June 2021. Interview on 8/13/21 with the Program Director revealed: -She was aware that some of the clients had not received their required monthly face to face counseling sessions. -One of the counselors had resigned in June and she had not been able to fill in the position. -She had been advertising the position as well as placing a $1000 incentive for new hires. -She was having a hard time to fill in the position with new candidates. -She had taken over the caseload of the Counselor that had left. -She was placing more attention on clients deemed as more "fragile." -She acknowledged that facility failed to ensure program compliance in the area of Individual Counseling requirements.	V 237		
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,	V 536		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL068-159	A. BUILDING: _____ B. WING _____	R 08/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLSBOROUGH RECOVERY SOLUTIONS	129 MAYO STREET HILLSBOROUGH, NC 27278

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 536	Continued From page 9 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. (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	V 536		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL068-159	A. BUILDING: _____ B. WING _____	R 08/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLSBOROUGH RECOVERY SOLUTIONS	129 MAYO STREET HILLSBOROUGH, NC 27278

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 536	Continued From page 10	V 536		

assisting in the person's involvement in making decisions about their life;
(7) skills in assessing individual risk for escalating behavior;
(8) communication strategies for defusing and de-escalating potentially dangerous behavior; and
(9) positive behavioral supports (providing 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL068-159	A. BUILDING: _____ B. WING _____	R 08/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLSBOROUGH RECOVERY SOLUTIONS	129 MAYO STREET HILLSBOROUGH, NC 27278

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 536	Continued From page 11	V 536		

to Subparagraph (i)(5) of this Rule.
(5) Acceptable instructor training programs shall include but are not limited to presentation of:
(A) understanding the adult learner;
(B) methods for teaching content of the course;
(C) methods for evaluating trainee performance; and
(D) documentation procedures.
(6) Trainers shall have coached experience teaching a training program aimed at preventing, reducing and eliminating the need for restrictive interventions at least one time, with positive review by the coach.
(7) Trainers shall teach a training program aimed at preventing, reducing and eliminating the need for restrictive interventions at least once annually.
(8) Trainers shall complete a refresher instructor training at least every two years.
(j) Service providers shall maintain documentation of initial and refresher instructor 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL068-159	A. BUILDING: _____ B. WING _____	R 08/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLSBOROUGH RECOVERY SOLUTIONS	129 MAYO STREET HILLSBOROUGH, NC 27278

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 536	Continued From page 12 as for trainers. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure three of five audited staff (Lead Nurse, Counselor, Nurse #2) had current training in the use of alternatives to restrictive interventions. The findings are: Review on 8/13/21 of the lead Nurse's personnel record revealed: -She was hired on 8/27/17. -She was hired as a Nurse -She did not have documentation of Training on Alternatives to Restrictive Intervention or a waiver form. Review on 8/13/21 of the Counselor's personnel record revealed: -He was hired on 1/12/21. -He was hired as a Counselor. -He did not have documentation of Training on Alternatives to Restrictive Intervention on file. Review on 8/13/21 of the Nurse #2's personnel records revealed: -She was hired on 12/21/20. -She was hired as a Nurse. -She did not have documentation of Training on Alternatives to Restrictive Intervention or a waiver form. Interview on 8/13/21 with the Program Director	V 536		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL068-159	A. BUILDING: _____ B. WING _____	R 08/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLSBOROUGH RECOVERY SOLUTIONS	129 MAYO STREET HILLSBOROUGH, NC 27278

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 536	Continued From page 13 revealed: -The facility used NCI Plus for training in Alternative to Restrictive Interventions. -She was under the impression that new staff had a few month's to get their training on Alternatives to Restrictive Intervention completed. -She would be scheduling training on alternatives to restrictive intervention for all staff that needed it. -She confirmed the Lead Nurse, Counselor and Nurse #2 did not have current training on Alternatives to Restrictive Intervention.	V 536		