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EDEN SQUARE	219 NORTH FOUSHEE STREET ROXBORO, NC 27573

(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 survey was completed on September 8, 2021. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G 5600A Supervised Living for Adults with Mental Illness.	V 000		
V 107	27G .0202 (A-E) Personnel Requirements 10A NCAC 27G .0202 PERSONNEL REQUIREMENTS (a) All facilities shall have a written job description for the director and each staff position which: (1) specifies the minimum level of education, competency, work experience and other qualifications for the position; (2) specifies the duties and responsibilities of the position; (3) is signed by the staff member and the supervisor; and (4) is retained in the staff member's file. (b) All facilities shall ensure that the director, each staff member or any other person who provides care or services to clients on behalf of the facility: (1) is at least 18 years of age; (2) is able to read, write, understand and follow directions; (3) meets the minimum level of education, competency, work experience, skills and other qualifications for the position; and (4) has no substantiated findings of abuse or neglect listed on the North Carolina Health Care Personnel Registry. (c) All facilities or services shall require that all applicants for employment disclose any criminal conviction. The impact of this information on a decision regarding employment shall be based	V 107		

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V 107	Continued From page 1 upon the offense in relationship to the job for which the applicant is applying. (d) Staff of a facility or a service shall be currently licensed, registered or certified in accordance with applicable state laws for the services provided. (e) A file shall be maintained for each individual employed indicating the training, experience and other qualifications for the position, including verification of licensure, registration or certification. This Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure one of three audited staff (Staff #1) met the minimum level of education requirements. The findings are: Review on 9/7/21 of Staff #1's personnel file revealed: -Staff #1 had a hire date of 12/4/20. -Staff #1 was hired as a Group Home Habilitation Technician -There was no documentation Staff #1 met the minimum level of education required. Interview on 9/8/21 with the President revealed: -He was sure that Staff #1 had submitted documentation regarding his education. -Proof of education for Staff #1 may had been wrongfully filed. -He confirmed Staff #1 had no documentation	V 107		

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V 107	Continued From page 2 that he met minimum level of education required.	V 107		
V 108	27G .0202 (F-I) Personnel Requirements 10A NCAC 27G .0202 PERSONNEL REQUIREMENTS (f) Continuing education shall be documented. (g) Employee training programs shall be provided and, at a minimum, shall consist of the following: (1) general organizational orientation; (2) training on client rights and confidentiality as delineated in 10A NCAC 27C, 27D, 27E, 27F and 10A NCAC 26B; (3) training to meet the mh/dd/sa needs of the client as specified in the treatment/habilitation plan; and (4) training in infectious diseases and bloodborne pathogens. (h) Except as permitted under 10a NCAC 27G .5602(b) of this Subchapter, at least one staff member shall be available in the facility at all times when a client is present. That staff member shall be trained in basic first aid including seizure management, currently trained to provide cardiopulmonary resuscitation and trained in the Heimlich maneuver or other first aid techniques such as those provided by Red Cross, the American Heart Association or their equivalence for relieving airway obstruction. (i) The governing body shall develop and implement policies and procedures for identifying, reporting, investigating and controlling infectious and communicable diseases of personnel and clients.	V 108		

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V 108	Continued From page 3 This Rule is not met as evidenced by: Based on record reviews and interview, the facility failed to ensure staff had training in Cardiopulmonary Resuscitation and First Aid for one of three audited staff audited (Staff #1). The findings are: Review on 9/7/21 of Staff #1's personnel file revealed: -Staff #1 had a hire date of 12/4/20. -Staff #1 was hired as a Group Home Habilitation Technician -There was no documentation of Cardiopulmonary Resuscitation and First Aid training on file for Staff #1. Interview on 9/8/21 with the President revealed: -Staff #1 spent time alone with the clients at the house. -He believed that Staff #1 had completed training on First Aid and Cardiopulmonary Resuscitation and it may had been wrongfully filed. -He confirmed Staff #1 had no documentation of training in Cardiopulmonary Resuscitation and First Aid.	V 108		
V 112	27G .0205 (C-D) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (c) The plan shall be developed based on the assessment, and in partnership with the client or legally responsible person or both, within 30 days of admission for clients who are expected to receive services beyond 30 days.	V 112		

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V 112	Continued From page 4 (d) The plan shall include: (1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement; (2) strategies; (3) staff responsible; (4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both; (5) basis for evaluation or assessment of outcome achievement; and (6) written consent or agreement by the client or responsible party, or a written statement by the provider stating why such consent could not be obtained. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to have a Person Centered Plan with 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 affecting one of three clients Client #3). The findings are: Review on 9/3/21 of Client #3's record revealed: -Admission date of 5/1/18. -Diagnoses Schizophrenia; Anxiety; Constipation due to medications -He was his own guardian. -Client #3's Person Centered Plan was completed but it was not signed by the client, physician or	V 112		

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V 112	Continued From page 5 qualified professional. Interview on 9/8/21 with the President revealed: -The Qualified Professional was responsible for completing the Person Centered Plans. -He did not know why updated plan for Client #3 was not signed by the client. -He confirmed that the Person Centered Plan for Client #3 had no written consent or agreement by the client.	V 112		
V 114	27G .0207 Emergency Plans and Supplies 10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES (a) A written fire plan for each facility and area-wide disaster plan shall be developed and shall be approved by the appropriate local authority. (b) The plan shall be made available to all staff and evacuation procedures and routes shall be posted in the facility. (c) Fire and disaster drills in a 24-hour facility shall be held at least quarterly and shall be repeated for each shift. Drills shall be conducted under conditions that simulate fire emergencies. (d) Each facility shall have basic first aid supplies accessible for use. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to conduct fire and disaster drills under conditions that simulate emergencies at least quarterly and repeated for each shift. The findings are:	V 114		

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V 114	Continued From page 6 Record review on 9/3/21 of the facility's fire drill log revealed: -3/2/21- 6:30 pm- 2nd shift -4/2/21- 2:57 pm- 1st shift -5/23/21- 6:55 am- 3rd shift -There was no evidence that fire drills had been conducted on 1st, 2nd and 3rd shift for the fourth quarter of 2020. -There was no evidence that fire drills had been conducted on 1st and 3rd shift for the first quarter of 2021. -There was no evidence that fire drills had been conducted on 2nd shift for the second quarter of 2021. Record review on 9/3/21 of the facility's disaster drill log revealed: -3/2/21- 7:00 pm- 2nd shift -4/2/21- 3:00 pm- 1st shift -5/23/21- 11:00 pm- 3rd shift -There was no evidence that disaster drills had been conducted on 1st, 2nd and 3rd shift for the fourth quarter of 2020. -There was no evidence that disaster drills had been conducted on 1st and 3rd shift for the first quarter of 2021. -There was no evidence that disaster drills had been conducted on 2nd shift for the second quarter of 2021. Interview on 9/3/21 with the Staff #1 revealed: -House operated under three shifts. -First shift was from 8:00 am to 5:00 pm. Second shift was from 5:00 pm to 12:00 am. Third shift was from 12:00 am to 8:00 am. -Fire and disaster drills were turned in to the main office when they were completed. Interview on 9/8/21 with the President revealed: -He was under the impression that fire and	V 114		

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V 114	Continued From page 7 disaster drills had been conducted; however, staff was not able to locate the missing drills. -He confirmed staff failed to conduct fire and disaster drills under conditions that simulate emergencies under each shift on each quarter.	V 114		
V 121	27G .0209 (F) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (f) Medication review: (1) If the client receives psychotropic drugs, the governing body or operator shall be responsible for obtaining a review of each client's drug regimen at least every six months. The review shall be to be performed by a pharmacist or physician. The on-site manager shall assure that the client's physician is informed of the results of the review when medical intervention is indicated. (2) The findings of the drug regimen review shall be recorded in the client record along with corrective action, if applicable. This Rule is not met as evidenced by: Based on record reviews and interview the facility failed to obtain drug reviews every six months for three of three clients (#1, #2 and #3) who received psychotropic drugs. The findings are: Review on 9/3/21 of Client #1's record revealed: -Admission date of 10/21/19. -Diagnoses of Autism Spectrum Disorder; Post Traumatic Stress Disorder; Attention Deficit Hyperactivity Disorder; Intermittent Explosive Disorder.	V 121		

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V 121	Continued From page 8 -Physician's order dated 8/20/21: -Fluoxetine 20 milligram (mg), 3 capsules every morning. -Vraylar 6 mg, 1 capsule every day. -Methylphenidate 27 mg, 1 tablet every morning. -Trazodone 50 mg, 1 tablet at bedtime. -Physician's order dated 11/2/20: -Lorazepam 1 mg, 1 tablet twice a day as needed for agitation. -The July, August and September 2021 Medication Administration Record (MAR) revealed Client #1 was administered the above medications daily. Last medication review on file was dated 9/17/20. -There was no evidence of a psychotropic drug review for Client #1's medications in the last six months. Review on 9/3/21 of Client #2's record revealed: -Admission date of 7/2/10. -Diagnoses of Intellectual Disability; Psychiatric Disorder; Mixed Hyperlipidemia; Obesity; Morbid Diabetes Mellitus; Hypertension; Gastroesophageal Reflux Disease. -Physician's order dated 7/22/21: -Fluoxetine 20 mg, 1 capsule a day. -Physician's order dated 10/15/20: -Olanzapine 10 mg, 1 tablet at bedtime -Lamotrigine 200 mg, 1 tablet a day. -Benztropine 2 mg, 1 tablet a day. -The July, August and September 2021 Medication Administration Record (MAR) revealed Client #2 was administered the above medications daily. -Last medication review on file was dated 10/30/20. -There was no evidence of a psychotropic drug review for Client #2's medications in the last six months.	V 121		

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V 121	Continued From page 9 Review on 9/3/21 of Client #3's record revealed: -Admission date of 5/1/18. -Diagnoses of Schizophrenia; Anxiety; Constipation due to medications. -Physician's order dated 3/16/21: -Escitalopram 20 mg, 1 tablet a day. Physician's order dated 6/3/21: -Clozapine 100 mg, 3 tablets in the morning. -Repairable 5 mg, 1 tablet a day. -Lamotrigine 100 mg, 1 tablet twice daily. -Benztropine, 2 tablets twice a daily. -Clozapine 100 mg, 2 1/2 tablets at bedtime. -The July, August and September 2021 Medication Administration Record (MAR) revealed Client #3 was administered the above medications daily. -There was no evidence of a psychotropic drug review for Client #3's medications in the last six months. Interview on 9/8/21 with the President revealed: -He was not aware that a psychotropic drug review for Clients #1, #2 and #3 had not been completed. -He would have pharmacist review the client's psychotropic medications. -He confirmed the six months psychotropic drug review for Clients #1, #2 and #3 were not completed.	V 121		
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	V 536		

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V 536	Continued From page 10 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. (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	V 536		

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V 536	Continued From page 11 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). (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.	V 536		

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(4) The content of the instructor training the service provider plans to employ shall be approved by the Division of MH/DD/SAS pursuant to Subparagraph (i)(5) of this Rule.
(5) Acceptable instructor training programs shall include but are not limited to presentation of:
(A) understanding the adult learner;
(B) methods for teaching content of the course;
(C) methods for evaluating trainee performance; and
(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

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V 536	Continued From page 13 competence by completion of coaching or train-the-trainer instruction. (l) Documentation shall be the same preparation as for trainers. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure three of three audited Staff (#1, #2 and #3) had current training in the use of alternatives to restrictive interventions. The findings are: Review on 9/7/21 of Staff #1's personnel records revealed: -He had a hire date of 12/4/20. -Staff #1 was hired as a Group Home Habilitation Technician. -There was no evidence that training on Alternatives to Restrictive Intervention had been completed. Review on 9/7/21 of Staff #2's personnel records revealed: -She had a hire date of 11/20/17. -Staff #2 was hired as a Group Home Habilitation Technician. -There was no evidence of a current training on Alternatives to Restrictive Intervention. Review on 9/3/21 of Staff #3's personnel records revealed: -She had a hire date of 3/15/12. -Staff #3 was hired as a Group Home Habilitation	V 536		

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V 536	Continued From page 14 Technician. -EBPI Interventions certificate expired on 7/31/21. -There was no evidence of a current training on Alternatives to Restrictive Intervention. Interview on 9/8/21 with the President revealed: -The group home was using the Evidence Based Practice Institute - EBPI Interventions training. -He was aware that some of the staff's training had expired, but because of state's COVID-19 situation, they had not been completed. -He confirmed Staffs #1, #2 and #3 did not have current training on Alternatives to Restrictive Intervention.	V 536		