STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL065-268	A. BUILDING: _____ B. WING _____	09/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILMINGTON HOME	28 BEAURAGARD DRIVE WILMINGTON, NC 28412

(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 17, 2021. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G. 5600C Supervised Living for Adults with Developmental Disability.	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 implement policies and procedures for identifying, reporting, investigating and controlling infectious and communicable diseases of personnel and	V 108		

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V 108	Continued From page 1 clients. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure 2 of 3 staff audited (Staff #1, #5) were trained in basic first aid (FA) including seizure management, and cardiopulmonary resuscitation (CPR) and the Heimlich maneuver; and 3 of 3 staff audited (Staff #1, #3, #5) were not trained on wound care to meet the needs of client #1. The findings are: Finding #1: Review on 9/16/21 of Staff #1's record revealed: -Hire date: 6/30/21. -Position: Direct Support Professional -No documentation of CPR or FA training. -No documentation of training on wound care. Interview on 9/15/21 Staff #1 stated: -This was her first job in a group home. -Her training had included on line training and working along side of the Qualified Professional (QP) to be trained on things such as how to use the lift device for clients #1 and #3. -The registered nurse provided a medication class. -Client #1 had an area of skin breakdown over her "tail bone." They would keep her diaper off when in bed and position her on her side. -If client #1 wore a diaper they would put a dressing over the area using the Medihoney (used for wound healing). -She had worked as the only staff on duty with all 3 clients present.	V 108		

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V 108	Continued From page 2 Finding #2: Review on 9/16/21 of Staff #5's record revealed: -Hire date: 7/2/21. -Position: Direct Support Professional -No documentation of CPR or FA training. -No documentation of training on wound care. Interview on 9/16/21 Staff #5 stated: -She had been working about 4 months; she had worked in the home previously and had resigned in December 2020. -She typically worked the evening shift. -She would be the only staff on duty, or have a second staff on duty with her. -She had been certified in FA/CPR in the past but she could not recall when she took the class or when it expired. -She had been trained on bed sores, getting the clients out of bed, client #2's seizure protocol, medication administration. -They cleaned client #1's wound and applied the "proper" medication, "depending on how bad it is." -The Duoderm (wound dressing) and Medihoney were used to get the wound to heal and the Zinc (topical ointment used for minor skin irritations) was used to prevent skin breakdown. Finding #3: Review on 9/16/21 of Staff #3's record revealed: -Hire date: 6/24/21. -Position: Direct Support Professional -CPR/FA certification dated 10/23/19. -No documentation of training on wound care. Interview on 9/16/21 Staff #3 stated: -She had medication training by the Registered Nurse, how to use the lift by the Qualified Professional (QP), and on line classes.	V 108		

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V 108	Continued From page 3 -The QP trained her on client #1's seizures. She was taught if the seizure is more than 5 minutes to put him on his side, do a "nasal pump," and call 911. -She typically worked the night shift and would be the only staff on duty Tuesdays through Saturdays. -She "looks" and if client #1's bedsore is "broken down" she would not apply the Zinc. The area was "open but healing" currently and she had applied the Medihoney that morning. -She was currently certified in CPR/FA. Refer to V118 for specific information about wound care orders and administration for client #1.	V 108		
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:	V 114		

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V 114	Continued From page 4 Based on record reviews, observations, and interviews, the facility failed to hold fire and disaster drills at least quarterly on each shift under conditions that simulated fire emergencies. The findings are: Interviews on 9/15/21 and 9/16/21 the Qualified Assurance/Improvement Coordinator stated: -There were 3 shift as follows: -1st shift: 7 am - 3 pm -2nd shift: 3 pm - 11 pm -3rd shift: 11 pm - 7 am -Minimum staff was one paraprofessional on duty. -There maximum client to staff ratio was 1 staff for 3 clients. Observations on 9/15/21 between 3 and 5 pm revealed: -2 client rooms had over bed electric patient lifts. -Client #1 and #3 were in wheelchairs and were non-ambulatory. Review of fire and disaster drills from 1/1/21 to 9/14/21 revealed: -1/1/21 - 3-31/21: No disaster drill documented on the 2nd shift. -4/1/21 - 6/30/21: No disaster drill documented for the 1st shift. -5/31/21 fire drill at 6:10 pm with the Qualified Professional and the 3 clients documented client #2 refused to leave the house and did not understand the danger of fire. -There were no drills documented that simulated a fire emergency with the minimum of 1 paraprofessional staff and 3 clients at a time that clients #1 and #3 would have to be transferred from their beds. Interview on 9/15/21 Staff #1 stated: -She had done a fire and weather disaster drill in	V 114		

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V 114	Continued From page 5 August 2021. -She had worked as the only staff on duty with the 3 clients. -If there was a fire and the clients were in bed, she was not sure she could get all 3 clients out of the house safely. Interview on 9/16/21 Staff #3 stated: -She worked the 3rd shift. -Tuesday through Thursdays she would work as the only staff on duty. -She had not done a fire or disaster drill without another staff. -She did not think she could evacuate all 3 clients without another staff in the event of a fire. -She had been trained on fire and disaster drills, but it did not include how to prioritize the external evacuation of the 3 clients.	V 114		
V 118	27G .0209 (C) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (c) Medication administration: (1) Prescription or non-prescription drugs shall only be administered to a client on the written order of a person authorized by law to prescribe drugs. (2) Medications shall be self-administered by clients only when authorized in writing by the client's physician. (3) Medications, including injections, shall be administered only by licensed persons, or by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer medications. (4) A Medication Administration Record (MAR) of all drugs administered to each client must be kept current. Medications administered shall be	V 118		

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V 118	Continued From page 6 recorded immediately after administration. The MAR is to include the following: (A) client's name; (B) name, strength, and quantity of the drug; (C) instructions for administering the drug; (D) date and time the drug is administered; and (E) name or initials of person administering the drug. (5) Client requests for medication changes or checks shall be recorded and kept with the MAR file followed up by appointment or consultation with a physician. This Rule is not met as evidenced by: Based on record review and interview the facility failed to administer medications as ordered by the physician affecting 1 of 3 clients audited (client #1). The findings are: Review on 9/16/21 of client #1's record revealed: -37 year old female admitted 10/19/20. -Diagnoses included BPAN (beta-propeller protein associated neurodegeneration); profound intellectual disability; seizure disorder; migrational anomaly lissencephaly; non-verbal. -Treatment plan dated 6/1/21 documented, "Attention should be given to keeping her ears clean because she does get a large buildup of wax." -Treatment plan dated 6/1/21 documented, "[Client #1] has started getting bed sores this past year, 3 so far. These were all on her backside in an area that is prone to skin breakdown." -Orders dated 7/22/21 included:	V 118		

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V 118	Continued From page 7 -Zinc Oxide 20% ointment, apply to sacrum twice daily. Do not apply to open wounds. (Prevent skin breakdown) -Medihoney 2"x 2" dressing, apply as needed directly over wound bed. (Wound healing) -Duoderm 4"x4" dressing; apply as needed to outer layer over silvercel dressing. (Wound healing) -Skin Prep wipes; apply as needed to peri wound as needed for skin barrier. (prevent skin breakdown) -Debrox 6.5%, place 3 drops in each ear canal every day for the first 5 days of each month. (Prevent ear wax buildup) -There were no orders for a silvercel dressing. -There were no orders to clarify how long the Medihoney dressing was to be used when the wound opened before resuming the Zinc Oxide. -There were no orders to clarify how staff were to determine when to use the skin prep wipes to client #1's peri wound. Review on 9/16/21 of client #1's July MARs from 7/22/21 - 7/31/21 revealed: -Staff documented Zinc Oxide 20 % was not administered twice daily on 7/22/21, not administered on the day shift 7/23/21, and not administered on 7/25/21 because of open bed sores. -Staff documented Zinc Oxide 20% was administered on the evening shift 7/23/21, and twice on 7/24/21. -No documentation Medihoney dressing was administered to the open wound between 7/22/21 and 7/24/21. -No documentation Skin Prep wipes were administered between 7/22/21 and 7/24/21. Review on 9/16/21 of client #1's August 2021 MARs revealed:	V 118		

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V 118	Continued From page 8 -Staff documented Zinc Oxide 20 % was not administered on the day shift 8/6/21, 8/16/21, 8/17/21, 8/18/21 because of open wound, but was administered on the evening shift for each of those dates. -Staff documented Zinc Oxide 20 % was administered on the day shift 8/19/21, but was not administered on the evening shift because the wound was open. -Staff documented both Duoderm and Medihoney were administered at 8:54 am on 8/16/21. -No documentation Skin Prep wipes were administered in August 2021. Review on 9/16/21 of client #1's September 2021 MARs revealed: -Staff documented Zinc Oxide 20 % was not administered on the day shift 9/8/21, 9/9/21, 9/12/21, 9/14/21 because the wound was open, but was administered on the evening shift for each of those dates. -The MAR was blank for Zinc Oxide 20% ointment scheduled for day shift on 9/14/21. -Staff documented Medihoney had been administered to an open bed sore on 9/13/21 at 8:36 am; 9/14/21 at 9:14 am; 9/15/21 at 5:11 pm. -Staff documented Duoderm was administered on 9/15/21 at 5:11 pm (same time as the Medihoney was administered). -No documentation Skin Prep wipes were administered in September 2021. -Debrox 6.5% ear drops were not documented as administered in September 2021. Interview on 9/15/21 Staff #1 stated: -Client #1 had an area of skin breakdown over her "tail bone." They would keep her diaper off when in bed and position her on her side. -If client #1 wore a diaper they would put a dressing over the area using the Medihoney	V 118		

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V 118	Continued From page 9 (used for wound healing). Interview on 9/16/21 Staff #5 stated: -They cleaned client #1's wound and applied the "proper" medication, "depending on how bad it is." -The Duoderm and Medihoney were used to get the wound to heal and the Zinc was used to prevent skin breakdown. Interview on 9/16/21 Staff #3 stated: -She "looks" and if client #1's bedsore is "broken down" she will not apply the Zinc. The area was "open but healing" currently and she had applied the Medihoney that morning. Interview on 9/16/21 the Qualified Professional stated: -Client #1's Debrox ear drops had not printed to the September MAR; therefore, had not been administered. -She had become aware from the staff on 9/8/21 at a staff meeting this had occurred. -The physician had not been contacted about the omission and the drops had not been administered for September. Interview on 9/17/21 the Registered Nurse stated: -Alternating Zinc Oxide (closed wound) and Metahoney (open wound) in the same day did not seem to be consistent with the indications for these medications. -She would consult with the staff to make sure those orders for client #1's wound care were better understood and applied correctly.	V 118		
V 123	27G .0209 (H) Medication Requirements 10A NCAC 27G .0209 MEDICATION	V 123		

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V 123	Continued From page 10 REQUIREMENTS (h) Medication errors. Drug administration errors and significant adverse drug reactions shall be reported immediately to a physician or pharmacist. An entry of the drug administered and the drug reaction shall be properly recorded in the drug record. A client's refusal of a drug shall be charted. . This Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure medication errors were reported immediately to a physician or pharmacist affecting 2 of 3 clients audited (clients #1 and #2). The findings are: Finding #1: Review on 9/16/21 of client #1's record revealed: -37 year old female admitted 10/19/20. -Diagnoses included BPAN (beta-propeller protein associated neurodegeneration); profound intellectual disability; seizure disorder; migrational anomaly lissencephaly; non-verbal. -Treatment plan dated 6/1/21 documented, "Attention should be given to keeping her ears clean because she does get a large buildup of wax." -Orders dated 7/22/21 included: -Debrox 6.5%, place 3 drops in each ear canal every day for the first 5 days of each month. (ear wax buildup) -Tizanidine 4 mg (milligrams) twice daily. (muscle spasms) -Baclofen 10 mg 3 times daily. (muscle	V 123		

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V 123	Continued From page 11	V 123		

spasms)
-Carbidopa-Levodopa (Carb/Levo) 25-100 mg 3 times daily. (Parkinson-like symptoms)

Review on 9/16/21 of client #1's September 2021 MARs revealed Debrox 6.5% ear drops were not documented as administered in September 2021.

Finding #2:
Review on 9/16/21 of client #2's record revealed:
-37 year old male admitted 10/19/20.
-Diagnoses included severe intellectual disability; Dravet syndrome; BRCA (breast cancer gene mutation) positive; severe epilepsy; osteoporosis; hypogonadism; asthma.
-Order dated 6/30/21 for Gabapentin 300 mg 3 times daily. (anticonvulsant)

Review on 9/16/21 of a Fax transmission dated 8/19/21 revealed:
-The fax was sent from the Qualified Professional (QP) to the primary care physician for client #1 and #2.
-Comments: "Notification of med (medication) errors in August. We are required to notify MD (medical doctor)."
-Attached memo read, "We are required to inform you of medication errors... You do not need to do anything with this information, I just needed to notify you."
-"8/3/21: [Client #1] did not receive her 4 pm Tizanidine. [Client #1] received an extra Carb/Levo and an extra Baclofen. No adverse side effects occurred. [Client #1] was observed and no changes noted."
-"8/1/21: [Client #2] did not receive his 2 pm Gabapentin. Was not discovered until the next day so dose was completely missed. No adverse side effects noted."

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V 123	Continued From page 12 Interviews on 9/16/21 and 9/17/21 the QP stated: -She did not realize reporting of medication errors had to be done immediately or that she could also report to a pharmacist. -Client #1's Debrox ear drops had not printed to the September medication administration record; therefore, had not been administered. -Staff reported the omission of client #1's ear drops to the QP on 9/8/21 at a staff meeting. -The omission of client #1's ear drops in September 2021 had not been reported to her physician and had not been administered for September.	V 123		
V 290	27G .5602 Supervised Living - Staff 10A NCAC 27G .5602 STAFF (a) Staff-client ratios above the minimum numbers specified in Paragraphs (b), (c) and (d) of this Rule shall be determined by the facility to enable staff to respond to individualized client needs. (b) A minimum of one staff member shall be present at all times when any adult client is on the premises, except when the client's treatment or habilitation plan documents that the client is capable of remaining in the home or community without supervision. The plan shall be reviewed as needed but not less than annually to ensure the client continues to be capable of remaining in the home or community without supervision for specified periods of time. (c) Staff shall be present in a facility in the following client-staff ratios when more than one child or adolescent client is present: (1) children or adolescents with substance abuse disorders shall be served with a minimum of one staff present for every five or fewer minor clients present. However, only one staff need be	V 290		

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V 290	Continued From page 13 present during sleeping hours if specified by the emergency back-up procedures determined by the governing body; or (2) children or adolescents with developmental disabilities shall be served with one staff present for every one to three clients present and two staff present for every four or more clients present. However, only one staff need be present during sleeping hours if specified by the emergency back-up procedures determined by the governing body. (d) In facilities which serve clients whose primary diagnosis is substance abuse dependency: (1) at least one staff member who is on duty shall be trained in alcohol and other drug withdrawal symptoms and symptoms of secondary complications to alcohol and other drug addiction; and (2) the services of a certified substance abuse counselor shall be available on an as-needed basis for each client. This Rule is not met as evidenced by: Based on record reviews, observations, and interviews the facility failed to ensure staff-client ratios above the minimum number to enable staff to respond to individualized client needs in the event of an emergency affecting 3 of 3 clients (#1, #2, #3). The findings are: Finding #1: Review on 9/16/21 of client #1's record revealed: -37 year old female admitted 10/19/20. -Diagnoses included BPAN (beta-propeller protein associated neurodegeneration); profound intellectual disability; seizure disorder; migrational anomaly lissencephaly; non-verbal.	V 290		

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V 290	Continued From page 14 Review on 9/16/21 of client #1's ISP (individual service plan) dated 6/1/21 revealed: -Client #1 had "Parkinson-like tremor on both sides. When she tries to stretch out her arm these tremors have gotten worse. She has great difficulty with opening either hand fully; you can tell it is painful for her.... with her diagnosis of BPAN, her muscle tone will continue to decline and deteriorate. Her joints are stiffening and she has issues with all of her joints (elbows, hips, knees, fingers, etc)." -Required "extensive support" for lifting and/or transferring. -"...needs full physical support with getting up and down from any position... Her calf muscles are so tight she can no longer place her feet flat on the floor... she does not self propel... she uses a wheel chair." -"[Client #1] needs full support from staff to exit her home in the event of a fire. Her wheelchair needs to be used." Finding #2: Review on 9/16/21 of client #3's record revealed: -38 year old female admitted 10/19/20. -Diagnoses included Cerebral Palsy (CP); spastic quadriplegic; mild intellectual disability; muscle contractures; dystonia. Review on 9/16/21 of client #3's ISP dated 5/1/21 revealed: -Client #3 was able to use a joystick to navigate her motorized wheel chair. "If there is a tight space to navigate she requires support to ensure she does not run into anything and hurt herself or others." -"She cannot control her spasms and has been known to accidentally strike her supports while they provide her personal care."	V 290		

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V 290	Continued From page 15 -Unable to walk or use a "stander" due to severity of her CP and is dependent on others for all transferring and repositioning. -"Crisis Prevention and Intervention ... [Client #3] is physically not able to get anywhere by herself. In the event of an emergency, [client #3] would require total support to evacuate or ensure her safety." Finding #3: Review on 9/16/21 of client #2's record revealed: -37 year old male admitted 10/19/20. -Diagnoses included severe intellectual disability; Dravet syndrome; BRCA (breast cancer gene mutation) positive; severe epilepsy; osteoporosis; hypogonadism; asthma. Review on 9/16/21 of client #2's ISP dated 12/1/21 revealed: -Client #2 can become upset when there are transitions and exhibit behaviors such as pushing, hitting, screaming and pinching. -Client #2 had a "wide gait," balance issues, and difficulty processing information as a result of his surgery to split his corpus callosum to control seizures. "This causes [client #2] to fall and trip frequently." -"He needs to be monitored closely. [Client #2] will run in parking lots and also tends to fall a lot." -"He doesn't like crowds, loud noises or bright lights." -"He needs simple step directions. It takes him longer to process things." -"[Client #2] requires much assistance, monitoring and supervision throughout the day and night to meet his developmental needs and maintain his health, safety and well-being." -"Needs 1:1 support to ensure his safety when out in the community. He is not aware of dangers..."	V 290		

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V 290	Continued From page 16 -"Crisis Prevention and Intervention Significant Event(s) That May Cause Increased Stress/Trigger Crisis: Seizures- may be triggered by heat (he does not sweat), flashing lights, falling (or falling because of a seizure), being startled and going into sleep or coming out of sleep..." -"Full physical support" required to avoid health and safety hazards. -"Partial physical support" required for "ambulating and moving about." -"Close supervision required due to risk of wandering away." -Required "support to evacuate home in event of fire." Review on 9/16/21 of fire and disaster drills from 1/1/21 - 9/17/21 revealed: -Fire drill dated 5/31/21 at 6:10 pm: "[Client #2] refused to leave the house (does not understand the danger of "fire")." -Disaster drill for a "winter storm" dated 9/14/21 at 7 am: "[Staff #2] and [Staff #3] successfully got [client #3], [client #2], [client #1] in the hallway bathroom. [Client #2] Refused to go in the bathroom, we explained what was going on and he still refused." Observations on 9/15/21 between 3 pm and 5 pm revealed: -Over bed electric transfer lifts in the bed rooms of client #1 and #3. -Client #1 was in a wheelchair in the living room area of the home. -Client #3 arrived from her day program. With several attempts she was able to grasp the joy stick and navigate her wheelchair to her room. Interview on 9/15/21 Staff #1 stated: -She had done a fire and weather disaster drill in August 2021.	V 290		

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V 290	Continued From page 17 -She had worked as the only staff on duty with the 3 clients. -If there was a fire and the clients were in bed, she was not sure she could get all 3 clients out of the house safely. Interview on 9/16/21 Staff #3 stated: -She worked the 3rd shift. -Tuesday through Thursdays she worked as the only staff on duty. -She had not done a fire or disaster drill without another staff. -She did not think she could evacuate all 3 clients without another staff in the event of a fire. Interview on 9/16/21 the Quality Assurance/Improvement Coordinator stated: -Minimum staff for the facility was 1 awake staff. -The maximum client to staff ratio was 1 staff to 3 clients. Interview on 9/17/21 the Qualified Professional stated: -Client #2 would not be able to evacuate the home independently as staff evacuated the other clients. -Client #2 ran back into the home during one of the fire drills. -There had not been a fire drill at a time when clients were sleeping and there was only 1 staff on duty. Review on 9/17/21 of the Plan of Protection dated 9/17/21 and completed by the Quality Assurance/Improvement Coordinator revealed: -"What immediate action will the facility take to ensure the safety of the consumers in your care? Cape Fear Group Homes (Licensee) will make efforts to secure a second staff member for 3rd shift as quickly as possible. Two staff member	V 290		

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are currently scheduled for Sunday and Monday 3rd shift. From that time, CFGH (Cape Fear Group Homes) will have two 3rd shift staff, managers will fill in as necessary. One of the 3rd shift staff members may sleep on shift. A sleep station will be set up in the office. That staff member will be woken up if any emergency arises."
-"Describe you plans to make sure the above happens. CFGH currently has multiple adds out for employment, including sign on and retention bonuses. Managers will be available as needed to fill in. Please note: CFGH's Executive Director disagrees with this citation but will work diligently to comply with the recommendation."

The facility staffed with a minimum of 1 staff and 3 clients on the night shift. Clients #1 and #3 had over bed motorized lifts to move from the bed to their wheel chairs. Client #1's diagnoses included BPAN; profound intellectual disability; seizure disorder; migrational anomaly lissencephaly; and was non-verbal. Client #1's condition had declined to the point she required full support to transfer and would require full support to evacuate the home in the event of an emergency. Client #3's diagnoses included CP; spastic quadriplegic; muscle contractures; and dystonia. Client #3 was dependent on others to transfer from her bed to wheelchair and would require total support to evacuate the home in an emergency. Client #2's diagnoses included severe intellectual disability; Dravet syndrome; severe epilepsy; and osteoporosis. Client #2 was able to ambulate, but he was a fall risk due to his unsteady gait and balance. Client #2 required "full" physical support to avoid health and safety hazards, "partial" physical support for "ambulating and moving about," "close supervision" to prevent his "wandering away," and

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V 290	Continued From page 19 "support to evacuate home in event of fire." Client #2 had demonstrated in emergency drills an inability to follow staff directions for both internal and external evacuation procedures. Having 1 staff responsible for 2 clients that required full support to evacuate, and a 3rd client that required staff support and close supervision in the event of an emergency put the clients at substantial risk that death or serious physical harm would occur in an emergency situation. This deficiency constitutes a Type A2 rule violation for substantial risk of serious harm and must be corrected within 23 days. An administrative penalty of $500.00 is imposed. If the violation is not corrected within 23 days, an additional administrative penalty of $500.00 per day will be imposed for each day the facility is out of compliance beyond the 23rd day.	V 290		
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	V 536		

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V 536	Continued From page 20 gathered. (d) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (e) Formal refresher training must be completed by each service provider periodically (minimum annually). (f) Content of the training that the service provider wishes to employ must be approved by the Division of MH/DD/SAS pursuant to Paragraph (g) of this Rule. (g) Staff shall demonstrate competence in the following core areas: (1) knowledge and understanding of the people being served; (2) recognizing and interpreting human behavior; (3) recognizing the effect of internal and external stressors that may affect people with disabilities; (4) strategies for building positive relationships with persons with disabilities; (5) recognizing cultural, environmental and organizational factors that may affect people with disabilities; (6) recognizing the importance of and assisting in the person's involvement in making decisions about their life; (7) skills in assessing individual risk for escalating behavior; (8) communication strategies for defusing and de-escalating potentially dangerous behavior; and (9) positive behavioral supports (providing means for people with disabilities to choose activities which directly oppose or replace	V 536		

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V 536	Continued From page 21 behaviors which are unsafe). (h) Service providers shall maintain documentation of initial and refresher training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcomes (pass/fail); (B) when and where they attended; and (C) instructor's name; (2) The Division of MH/DD/SAS may review/request this documentation at any time. (i) Instructor Qualifications and Training Requirements: (1) Trainers shall demonstrate competence by scoring 100% on testing in a training program aimed at preventing, reducing and eliminating the need for restrictive interventions. (2) Trainers shall demonstrate competence by scoring a passing grade on testing in an instructor training program. (3) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (4) The content of the instructor training the service provider plans to employ shall be approved by the Division of MH/DD/SAS pursuant to Subparagraph (i)(5) of this Rule. (5) Acceptable instructor training programs shall include but are not limited to presentation of: (A) understanding the adult learner; (B) methods for teaching content of the course; (C) methods for evaluating trainee performance; and (D) documentation procedures. (6) Trainers shall have coached experience	V 536		

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V 536	Continued From page 22 teaching a training program aimed at preventing, reducing and eliminating the need for restrictive interventions at least one time, with positive review by the coach. (7) Trainers shall teach a training program aimed at preventing, reducing and eliminating the need for restrictive interventions at least once annually. (8) Trainers shall complete a refresher instructor training at least every two years. (j) Service providers shall maintain documentation of initial and refresher instructor training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcomes (pass/fail); (B) when and where attended; and (C) instructor's name. (2) The Division of MH/DD/SAS may request and review this documentation any time. (k) Qualifications of Coaches: (1) Coaches shall meet all preparation requirements as a trainer. (2) Coaches shall teach at least three times the course which is being coached. (3) Coaches shall demonstrate competence by completion of coaching or train-the-trainer instruction. (l) Documentation shall be the same preparation as for trainers. This Rule is not met as evidenced by: Based on record reviews and interview, the	V 536		

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V 536	Continued From page 23 facility failed to ensure 3 of 3 audited staff (#1, #3, #5) had training in the use of alternatives to restrictive interventions. The findings are: Finding #1: Review on 9/16/21 of Staff #1's record revealed: -Hire date: 6/30/21. -Position: Direct Support Professional. -No documentation of training in the use of alternatives to restrictive interventions. Finding #2: Review on 9/16/21 of Staff #3's record revealed: -Hire date: 6/24/21. -Position: Direct Support Professional. -No documentation of training in the use of alternatives to restrictive interventions. Finding #3: Review on 9/16/21 of Staff #5's record revealed: -Hire date: 7/2/21. -Position: Direct Support Professional. -No documentation of training in the use of alternatives to restrictive interventions. Interview on 9/16/21 the Quality Assurance/Improvement Coordinator stated: -The facility used CPI (Crisis Prevention Institute) for the curriculum to teach alternatives to restrictive interventions. -She verified with the Qualified Professional and none of the audited staff had completed the CPI training.	V 536		