Division of Health Service Regulation

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			71. BOILBING.		F	₹
		MHL100-023	B. WING		1	3/2021
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
CALLOW	AY COTTAGE	35 CELO S BURNSVII	STREET LLE, NC 28'	714		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
V 000	INITIAL COMMEN	гѕ	V 000			
		ow-Up Survey was completed 11. Deficiencies were cited.				
	This facility is licens category:	sed for the following service				
		G .5600C: Supervised Living elopmental Disabilities				
V 536	27E .0107 Client R Int.	ights - Training on Alt to Rest.	V 536			
	practices that emple to restrictive interverse (b) Prior to providing disabilities, staff incompletes, student demonstrate completes completing training other strategies for which the likelihood or injury to a person property damage is (c) Provider agence based on state concompliance and degathered. (d) The training shall include measurable	mplement policies and nasize the use of alternatives entions. In g services to people with cluding service providers, its or volunteers, shall etence by successfully in communication skills and creating an environment in d of imminent danger of abuse in with disabilities or others or				

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

Division of Health Service Regulation

TAG REGULATORY OR LSC IDENTIFYING INFORMATION) V 536 Continued From page 1 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	DIVISION	of Health Service Re	guiation				
MHL100-023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE				, ,			
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 35 CELO STREET BURNSVILLE, NC 28714 (X4) ID PREFIX TAG PREFIX TAG COMPLETIX REGULATORY OR LSC IDENTIFYING INFORMATION) V 536 Continued From page 1 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	AND FLAN	OI JOINEOTION	DENTILIDATION NOMBER.	A. BUILDING:			LLILD
NAME OF PROVIDER OR SUPPLIER CALLOWAY COTTAGE STREET ADDRESS, CITY, STATE, ZIP CODE 35 CELO STREET BURNSVILLE, NC 28714 (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) V 536 Continued From page 1 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						F	₹
CALLOWAY COTTAGE BURNSVILLE, NC 28714 (X4) ID PREFIX TAG CEACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) V 536 Continued From page 1 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			MHL100-023	B. WING		10/1	3/2021
CALLOWAY COTTAGE BURNSVILLE, NC 28714 (X4) ID PREFIX TAG CEACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) V 536 Continued From page 1 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	NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) V 536 Continued From page 1 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					,		
(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) V 536 Continued From page 1 Deficiency 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 Deficiency PREFIX TAG PREFIX TA	CALLOW	AY COTTAGE			714		
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) V 536 Continued From page 1 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	(V4) ID	SLIMMARV STA)N	(YE)
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	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI	D BE	COMPLETE DATE
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	V 536	Continued From pa	ge 1	V 536			
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 behaviors which are unsafe). (h) Service providers shall maintain documentation of initial and refresher training for		behavior) on those methods to determicourse. (e) Formal refreshed by each service proannually). (f) Content of the transproad provider wishes to each the Division of MH/IP Paragraph (g) of this (g) Staff shall demotollowing core areas (1) knowledge people being served (2) recognizing behavior; (3) recognizing behavior; (4) strategies relationships with programizational factor disabilities; (4) strategies relationships with programizational factor disabilities; (6) recognizing organizational factor disabilities; (6) recognizing assisting in the person decisions about the (7) skills in as escalating behavior (8) communication and de-escalating pand (9) positive behaviors which direst behaviors which direst behaviors which direst behaviors which direst behaviors which are (h) Service provides	objectives and measurable ne passing or failing the er training must be completed vider periodically (minimum raining that the service employ must be approved by DD/SAS pursuant to s Rule. Onstrate competence in the size and understanding of the digrand interpreting human and that may affect people with for building positive ersons with disabilities; and cultural, environmental and rest that may affect people with that may affect people with the general service of and son's involvement in making ir life; assessing individual risk for cation strategies for defusing totentially dangerous behavior; the environal supports (providing with disabilities to choose ctly oppose or replace enusafe).				

Division of Health Service Regulation

STATE FORM 6899 J4IY11 If continuation sheet 2 of 11

<u> Division</u>	of Health Service Re	gulation				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING:			
		MHL100-023	B. WING		F 10/1	? 3/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS CITY S	STATE, ZIP CODE	•	
TW UVIL OT	NOVIDER OR GOLF EIER	35 CELO		517/12, 211 GGBE		
CALLOV	/AY COTTAGE		LLE, NC 28	714		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
V 536	Continued From pa	ge 2	V 536			
	(1) Documen (A) who partic outcomes (pass/fail (B) when and (C) instructor (2) The Divisi review/request this (i) Instructor Qualif Requirements: (1) Trainers s by scoring 100% or aimed at preventing need for restrictive (2) Trainers s by scoring a passin instructor training p (3) The traini competency-based objectives, measura observation of beha measurable method failing the course. (4) The conte service provider pla approved by the Div to Subparagraph (i) (5) Acceptabl shall include but are (A) understan (B) methods course; (C) methods performance; and (D) document (6) Trainers s teaching a training reducing and elimin	tation shall include: ipated in the training and the); I where they attended; and Is name; on of MH/DD/SAS may documentation at any time. ications and Training I hall demonstrate competence I testing in a training program I, reducing and eliminating the interventions. I hall demonstrate competence I grade on testing in an rogram. Ing shall be I include measurable learning I able testing (written and by I vior) on those objectives and I dis to determine passing or I of the instructor training the Instructor training the Instructor training programs I of the instructor training the I of the instructor training programs I of the instructor training programs I of the instructor training the I of the instructor training				

Division of Health Service Regulation STATE FORM

Division of Health Service Regulation

DIVISION	of Health Service Re	guiation				
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPI	LETED
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		MHL100-023	B. WING			3/2021
NAME OF 5	200//050 00 01/00//50	0.70557.40		NATE TIP CORE		
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
CALLOW	AY COTTAGE	35 CELO		-4.4		
		BURNSVI	LLE, NC 28	714		
(X4) ID PREFIX		TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
TAG		SC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROP		DATE
				DEFICIENCY)		
V 536	Continued From pa	ge 3	V 536			
	·	_	. 555			
		shall teach a training program				
		g, reducing and eliminating the				
	annually.	interventions at least once				
	•	shall complete a refresher				
		t least every two years.				
	(j) Service provider					
		nitial and refresher instructor				
	training for at least	•				
	\ /	nentation shall include:				
	(A) who particle outcomes (pass/fail	ipated in the training and the				
), I where attended; and				
	(C) instructor					
		on of MH/DD/SAS may				
		this documentation any time.				
	(k) Qualifications o					
		shall meet all preparation				
	requirements as a t	rainer. shall teach at least three times				
	(2) Coaches the course which is					
		shall demonstrate				
		npletion of coaching or				
	train-the-trainer inst					
		shall be the same preparation				
	as for trainers.					
	This Rule is not me					
		and record review, the facility				
		mal refresher trainings on				
		ictive interventions were service provider periodically,				
	at least on an annu	al basis, for two (staff #2 and				

Division of Health Service Regulation

STATE FORM 6899 J4IY11 If continuation sheet 4 of 11

<u>Divisio</u> n	of Health Service Re	egulation				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		MHL100-023	B. WING		10/1	2 3/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
CALLOW	AY COTTAGE	35 CELO	STREET	,		
CALLOW	AT COTTAGE	BURNSVI	LLE, NC 287	714		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
V 536	Continued From pa	ge 4	V 536			
	the Qualified Profes surveyed. The findings are:	ssional) of three staff				
	record revealed: - hired 9-13-19 - position: - Direct Su	Restrictive Interventions				
	's (QP) personnel r - hired 10-8-18 - poiston: - QP	Restrictive Interventions				
	- there were 3 s Alternatives to Resi had expired last mo - when there ar training, they prefer 's location - used to have a just before the Co-V - "it's been ver times, due to Co-Vi with scheduling class come to their remot - "Alternatives t training has already and a trainer will be	e multiple staff needing the trainer come to the facility a trainer locally, "but she left //id pandemic" by difficult to get staff trained at d and the logistics associated asses and getting trainers to be location" o Restrictive Interventions been scheduled for 10-21-21,				

Division of Health Service Regulation

STATE FORM 6899 If continuation sheet 5 of 11 J4IY11

Division of Health Service Regulation

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING.		F	,
		MHL100-023	B. WING			3/2021
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
CALLOV	VAY COTTAGE	35 CELO				
			LLE, NC 28			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
V 536	Continued From pa	ge 5	V 536			
		e behaviors component, and I recognize it part of our services"				
V 537	27E .0108 Client Ri	ghts - Training in Sec Rest &	V 537			
	ISOLATION TIME-(a) Seclusion, physitime-out may be en been trained and had competence in the to these procedures staff authorized to eprocedures are retricompetence at least (b) Prior to providin disabilities whose traincludes restrictive service providers, evolunteers shall conseclusion, physical and shall not use the training is completed demonstrated. (c) A pre-requisited demonstrating comparting in preventing the need for restriction (d) The training shall include measurable measurable testing behavior) on those	SICAL RESTRAINT AND DUT sical restraint and isolation aployed only by staff who have ave demonstrated proper use of and alternatives as. Facilities shall ensure that employ and terminate these ained and have demonstrated at annually. If direct care to people with reatment/habilitation plan interventions, staff including employees, students or emplete training in the use of restraint and isolation time-out less interventions until the and and competence is for taking this training is petence by completion of ag, reducing and eliminating				

6899

Division of Health Service Regulation STATE FORM

J4IY11 If continuation sheet 6 of 11

Division of Health Service Regulation

DIVISION	of Health Service Re	guiation				
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		MHL100-023	B. WING		F 10/1	₹ 3/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS CITY S	STATE, ZIP CODE		
TW WILL OF	TROVIDER OR COLL FIER	35 CELO		517/12, 211 GGBE		
CALLOV	VAY COTTAGE		LLE, NC 28	714		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
V 537	Continued From pa	ge 6	V 537			
	by each service proannually). (f) Content of the transport of the Division of MH//Paragraph (g) of this (g) Acceptable train but are not limited to (1) refresher the use of restrictive (2) guidelines (understanding immothers); (3) emphasis rights and dignity of concepts of least reincremental steps in (4) strategies of restrictive interversions which assessment and many psychological well-buse of restrictive interventions which assessment and many psychological well-buse of restrictive interventions (6) prohibited (7) debriefing importance and pur (8) document (8) document (9) Service provided documentation of ir at least three years (1) Document (A) who particoutcomes (pass/fai	ning programs shall include, o, presentation of: information on alternatives to e interventions; son when to intervene ninent danger to self and on safety and respect for the fall persons involved (using estrictive interventions and nan intervention); for the safe implementation entions; femergency safety include continuous onitoring of the physical and being of the client and the safe aughout the duration of the on; procedures; strategies, including their pose; and tation methods/procedures. The shall maintain initial and refresher training for tation shall include: sipated in the training and the lies. It where they attended; and				

Division of Health Service Regulation

STATE FORM 6899 J4IY11 If continuation sheet 7 of 11

Division of Health Service Regulation

DIVISION	or riealth Service IN	syulation				
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	` '	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
					 	,
		MHL100-023	B. WING			3/2021
					1 10/1	J. 202 !
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
CALLOW	AY COTTAGE	35 CELO S				
OALLON	AT GOTTAGE	BURNSVII	LLE, NC 287	714		
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PRÉFIX		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF		COMPLETE DATE
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V 537	Continued From pa	ge 7	V 537			
	(2) The Divisi	ion of MH/DD/SAS may				
		documentation at any time.				
		ication and Training [*]				
	Requirements:	J				
		shall demonstrate competence				
		n testing in a training program				
	aimed at preventing	g, reducing and eliminating the				
	need for restrictive	interventions.				
		shall demonstrate competence				
		n testing in a training program				
	teaching the use of	seclusion, physical restraint				
	and isolation time-o					
		shall demonstrate competence				
		g grade on testing in an				
	instructor training p					
		ng shall be				
		, include measurable learning				
		able testing (written and by				
		avior) on those objectives and				
		ds to determine passing or				
	failing the course.	ant of the inetruster training the				
	` '	ent of the instructor training the				
		ins to employ shall be vision of MH/DD/SAS pursuant				
	to Subparagraph (j)					
		le instructor training programs				
		ot be limited to, presentation				
	of:	or so minica to, procentation				
		ding the adult learner;				
		for teaching content of the				
	course;	5				
		n of trainee performance; and				
		ation procedures.				
		shall be retrained at least				
		nstrate competence in the use				
		cal restraint and isolation				
		ed in Paragraph (a) of this				
	Rule.	2 . , ,				
		shall be currently trained in				

Division of Health Service Regulation STATE FORM

Division of Health Service Regulation

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,	E CONSTRUCTION	(X3) DATE	SURVEY LETED
		MHL100-023	B. WING		F 10/1	R 3/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
CALLOW	/AY COTTAGE	35 CELO 9	STREET			
CALLOW	MICOTIAGE	BURNSVII	LLE, NC 287	714		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
V 537	Continued From page	ge 8	V 537			
	CPR. (9) Trainers s in teaching the use least two times with coach. (10) Trainers s use of restrictive intannually. (11) Trainers s instructor training at (k) Service provide documentation of intraining for at least st. (1) Document (A) who particulation outcome (pass/fail); (B) when and (C) instructor (2) The Division review/request this (I) Qualifications of (1) Coaches strength requirements as a to (2) Coaches strength recourse work (3) Coaches strength requirements with the course work (3) Coaches strength requirements as a to coaches strength requirements with the course work (3) Coaches strength requirements as a to coache strength requirement requirements as a to coache strength requirement requirement requirements as a to coache strength requirement requirem	hall have coached experience of restrictive interventions at a positive review by the hall teach a program on the erventions at least once hall complete a refresher teast every two years. It is shall maintain itial and refresher instructor three years. It is that it is the training and the where they attended; and so name. On of MH/DD/SAS may documentation at any time. Coaches: Is shall meet all preparation rainer. Is shall teach at least three hich is being coached. It is being coached. It is shall demonstrate inpletion of coaching or ruction. In shall be the same rainers.				
		and record review the facility				

Division of Health Service Regulation STATE FORM

failed to ensure formal refresher trainings in

J4IY11 If continuation sheet 9 of 11

	<u>of Health Service Re</u>	egulation				
	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPI	LETED
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		MHL100-023	B. WING			3/2021
		WITE 100-023			10/1	3/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
		35 CELO 9	STREET			
CALLOW	AY COTTAGE		LLE, NC 287	714		
	OLD # 44 F) / OTA					
(X4) ID PREFIX		TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROI		DATE
				DEFICIENCY)		
V 537	Continued From no		V 537			
V 331	Continued From pa	ge 9	V 551			
	Seclusion, Physical	Restraint and Isolation				
		pleted by each service				
		γ, at least on an annual basis,				
		the Qualified Professional) of				
	three staff surveyed					
	The findings are:					
	J					
	Review on 10-13-2	1 of staff #2 ' s personnel				
	record revealed:	•				
	- hired 9-13-19					
	- position:					
	- Direct Su	pport Staff				
		ysical Restraint, and Isolation				
	Time-Out training e					
	ŭ	·				
	Review on 10-13-2	1 of the Qualified Professional				
	's (QP) personnel r	ecord revealed:				
	- hired 10-8-18					
	- poiston:					
	- QP					
	- Seclusion, Ph	ysical Restraint, and Isolation				
	Time-Out training e					
	3	-				
	Interview on 10-13-	21 with the QP revealed:				
	- there were 3 s	staff in the facility whose				
		Restraint, and Isolation				
	Time-Out training e					
		e multiple staff needing this				
		the trainer come to the facility				
	's location	•				
	- the agency us	ed to have a local trainer, "but				
		the Co-Vid pandemic"				
		ry difficult to get staff trained at				
		d and the logistics associated				
		sses and getting trainers to				
	come to their remot					
		as already been scheduled for				

Division of Health Service Regulation

Division of Health Service Regulation

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	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
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		MHL100-023	B. WING			3/2021
NAME OF F	PROVIDER OR SUPPLIER	CTDEFT ADI	DESS CITY O	STATE, ZIP CODE		
NAIVE OF F	- NOVIDER OR SUPPLIER			STATE, ZIF CODE		
CALLOW	AY COTTAGE	35 CELO S BURNSVII	LLE, NC 28	714		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
V 537	Continued From pa	ge 10	V 537			
V 537	10-21-21, and a tra - at the present issues of aggressiv - "It's a critical	iner will be coming here , there are no clients with	V 537			

Division of Health Service Regulation STATE FORM