Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		mhl041-818	B. WING		R 12/09/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	STATE, ZIP CODE	
SUCCES	SFUL TRANSITIONS,	LLC RESIDENTI	NDON DRIVE INT, NC 272		
(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 SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLÉTE
V 000	INITIAL COMMENT	-S	V 000		
	An annual and follo on 12/9/21. Deficier	w up survey was completed ncies were cited.			
	10A NCAC 27G .17	sed for the following service 00 Residential Treatment ildren or Adolescents.			
		consisted of audits of 3 rmer clients and 0 deceased			
V 107	27G .0202 (A-E) Pe	ersonnel Requirements	V 107		
	which: (1) specifies the competency, work of qualifications for the (2) specifies the the position; (3) is signed by supervisor; and (4) is retained (b) All facilities shat each staff member provides care or set the facility: (1) is at least 1 (2) is able to reserve the second staff to reserve the second s	Il have a written job director and each staff position e minimum level of education, experience and other e position; e duties and responsibilities of y the staff member and the in the staff member's file. Il ensure that the director, or any other person who rvices to clients on behalf of			
	competency, work equalifications for the (4) has no sub-	stantiated findings of abuse or e North Carolina Health Care			

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

TITLE (X6) DATE

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		mhl041-818		B. WING			R 09/2021
	PROVIDER OR SUPPLIER	LLC RESIDENTI	1458 LON	DRESS, CITY, S DON DRIVE NT, NC 2720			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
V 107	(c) All facilities or sapplicants for employed conviction. The implementation of the imp	pervices shall require comment disclose any pact of this informatic employment shall be relationship to the jo is applying. Yor a service shall be registered or certified eplicable state laws for an aintained for each in the training, experied for the position, inclusive and the state of the state of the position, inclusive and the state of	criminal on on a based b for e in or the dividual ence and	V 107			
	failed to ensure a ckept for 1 for 4 audit Professional (LP)). Review on 12/9/21 the Licensee #1 via - A "Contractor S 3/24/21 with no sign - No evidence of - A resume which history; however, no any of the colleges/	view and interview, the omplete personnel relited staff (the License The findings are: of the information processed in the informat	ecord was ed ovided by ated tion ational ma from the LP's				

Division of Health Service Regulation

STATE FORM 6899 QRE811 If continuation sheet 2 of 14

Division of Health Service Regulation

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BOILDING.		_	,
		mhl041-818	B. WING		12/0	9/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
01100=0		1458 LON	IDON DRIVE			
SUCCES	SFUL TRANSITIONS,	HIGH PO	NT, NC 2720	62		
(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 APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
V 107	Continued From page 2		V 107			
V 108	Qualified Professio The LP's perso the facility but inste company's office) She was only a she received via en	nnel record was not kept at ad offsite (the parent ble to provide the information nail from the Licensee #1.	V 108			
V 108	27G .0202 (F-I) Pei	rsonnel Requirements	V 108			
	(g) Employee train provided and, at a refollowing: (1) general organiz (2) training on clier delineated in 10A N 10A NCAC 26B; (3) training to meet client as specified in plan; and (4) training in infect bloodborne pathogory (h) Except as perm .5602(b) of this Submember shall be any times when a client member shall be traincluding seizure member shall be shall be shall be trainc	cation shall be documented. ing programs shall be minimum, shall consist of the rational orientation; nt rights and confidentiality as ICAC 27C, 27D, 27E, 27F and t the mh/dd/sa needs of the n the treatment/habilitation tious diseases and				

Division of Health Service Regulation

STATE FORM 6899 QRE811 If continuation sheet 3 of 14

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					SURVEY		
		mhl041-818		B. WING			२ 09/2021
	PROVIDER OR SUPPLIER SFUL TRANSITIONS,	LLC RESIDENTI.	1458 LON	DRESS, CITY, S DON DRIVE NT, NC 272			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC)	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
V 108	reporting, investigated and communicable clients.	ting and controlling ir diseases of personn		V 108			
V 536	failed to ensure a ckept for 1 for 4 audit Professional (LP)). Review on 12/9/21 the Licensee #1 via - A "Contractor S 3/24/21 with no sign - No evidence the general organization client rights and condiseases and blood information provide Interviews on 12/8/3 Qualified Profession - The LP's person the facility but instet company's office) - She was only a she received via en	view and interview, the omplete personnel relited staff (the License The findings are: of the information proceed email revealed: dervice Agreement" destruces present the LP had received trained orientation; training infidentiality and in infilation pathogens in the downward on 12/9/21 with the complete the complet	ecord was ed ovided by ated aining in ag on ectious he th the kept at ormation e #1.	V 536			
	Int. 10A NCAC 27E .01 ALTERNATIVES TO INTERVENTIONS	07 TRAINING O		, , , ,			

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Division of Health Service Regulation STATE FORM

QRE811 If continuation sheet 4 of 14

Division of Health Service Regulation									
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY LETED				
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	mhl041-818	B. WING			9/2021				
ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE						
SELII TRANSITIONS	LLC PESIDENTI 1458 LON	IDON DRIVE							
Brul TRANSITIONS,	HIGH PO	INT, NC 2720	62						
(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL	D BE	(X5) COMPLETE DATE				
Continued From pa	ge 4	V 536							
(a) Facilities shall in practices that emph to restrictive interve (b) Prior to providin disabilities, staff incemployees, student demonstrate compe completing training other strategies for which the likelihood or injury to a persor property damage is (c) Provider agencibased on state composed on state composed on state composed on the training shall include measurable measurable testing behavior) on those methods to determi course. (e) Formal refreshed by each service propannually). (f) Content of the training of MH/I Paragraph (g) of this (g) Staff shall demonstrate of the Division of MH/I Paragraph (g) of this (g) Staff shall demonstrate of the provider wishes to each service propannually). (g) Staff shall demonstrate of the training server (g) recognizing the people being server (g) recognizing the people server (g) recognizing external stressors the provider with the provider wishes to be the provider wishes to be the Division of MH/I Paragraph (g) of this (g) Staff shall demonstrate of the provider wishes to be the provider wishes the prov	mplement policies and nasize the use of alternatives entions. In g services to people with eluding service providers, its or volunteers, shall etence by successfully in communication skills and creating an environment in of imminent danger of abuse in with disabilities or others or prevented. It is shall establish training inpetencies, monitor for internal monstrate they acted on data all be competency-based, it learning objectives, (written and by observation of objectives and measurable in passing or failing the er training must be completed ovider periodically (minimum raining that the service employ must be approved by DD/SAS pursuant to its Rule. In sonstrate competence in the its eand understanding of the dig and interpreting human and the effect of internal and								
	ROVIDER OR SUPPLIER SFUL TRANSITIONS, SUMMARY STA (EACH DEFICIENCY REGULATORY OR LETT) Continued From pa (a) Facilities shall i practices that emph to restrictive interve (b) Prior to providir disabilities, staff incemployees, student demonstrate compecompleting training other strategies for which the likelihood or injury to a persor property damage is (c) Provider agence based on state components of the training shall include measurable testing behavior) on those methods to determine course. (e) Formal refreshed by each service property of the testing behavior of the training shall refreshed by each service property of the testing behavior of the training shall refreshed by each service property of the testing behavior of the training shall refreshed by the provider wishes to be the Division of MH/IP Paragraph (g) of the following core areas (1) knowledged people being server (2) recognizing the provider wishes to the training server (3) recognizing the property of the provider wishes to the following core areas (1) knowledged people being server (2) recognizing the provider wishes to the provider wishes to the provider wishes to the provider wishes to the following core areas (1) knowledged people being server (2) recognizing the provider wishes to the provider	TOF DEFICIENCIES DE CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: mhl041-818 ROVIDER OR SUPPLIER STREET AL 1458 LON HIGH PO SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 4 (a) Facilities shall implement policies and practices that emphasize the use of alternatives to restrictive interventions. (b) Prior to providing services to people with disabilities, staff including service providers, employees, students or volunteers, shall demonstrate competence by successfully completing training in communication skills and other strategies for creating an environment in which the likelihood of imminent danger of abuse or injury to a person with disabilities or others or property damage is prevented. (c) Provider agencies shall establish training based on state competencies, monitor for internal compliance and demonstrate they acted on data gathered. (d) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (e) Formal refresher training must be completed by each service provider periodically (minimum annually). (f) Content of the training that the service provider wishes to employ must be approved by the Division of MH/DD/SAS pursuant to Paragraph (g) of this Rule. (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;	TOF DEFICIENCIES OF CORRECTION Main Mai	TOF DEFICIENCIES OF CORRECTION (X1) PROVIDERSUPPLERICLLA (X2) MULTIPLE CONSTRUCTION A BUILDING: MINIOR: MINIOR: B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 1458 LONDON DRIVE HIGH POINT, NC 27262 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 4 (a) Facilities shall implement policies and practices that emphasize the use of alternatives to restrictive interventions. (b) Prior to providing 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 competence, monitor for internal compliance and demonstrate they acted on data gathered. (d) The training shall be competency-based, include measurable learning objectives, measurable learning objectives, measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or falling 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.	TOF DEFICIENCIES OF CORRECTION (X1) PROVIDERSUPPLIER (X2) MALTIPLE CONSTRUCTION (X3) DATE OF CORRECTION (X4) DATE OF COMP (X4) DATE OF				

Division of Health Service Regulation

STATE FORM 6899 If continuation sheet 5 of 14 **QRE811**

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	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPL		(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
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		mhl041-818		B. WING			
		111111041-010				12/0	9/2021
NAME OF F	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
			1458 LON	DON DRIVE			
SUCCES	SFUL TRANSITIONS,	LLC RESIDENTIA		NT, NC 2720	32		
	OUR MAA DV OTA	TEMENT OF DESIGNAN		1		211	
(X4) ID	_	TEMENT OF DEFICIENCI MUST BE PRECEDED B		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
PREFIX TAG		SC IDENTIFYING INFORM		TAG	CROSS-REFERENCED TO THE APPRO		DATE
					DEFICIENCY)		
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V 536	Continued From pa	ge 5		V 536			
	relationships with p	ersons with disabilit	ies:				
		ng cultural, environn					
	organizational facto						
	disabilities;	no that may ancot p	copic with				
		ng the importance o	fand				
	assisting in the pers						
	decisions about the		illiakilig				
			rick for				
	(7) skills in assessing individual risk for						
	escalating behavior (8) communic	, cation strategies for	dofucina				
	and de-escalating p						
		otentially dangerou	s benavior,				
	and	obovioral augments	'nrovidina				
		ehavioral supports					
	means for people w						
	activities which dire		ice				
	behaviors which are						
	(h) Service provide						
	documentation of ir		raining for				
	at least three years						
	\ <i>\</i>	tation shall include:					
		ipated in the trainin	g and the				
	outcomes (pass/fail						
		l where they attende	ea; and				
	(C) instructor	*					
	\ <i>\</i>	ion of MH/DD/SAS	•				
	review/request this						
	(i) Instructor Qualif	ications and Trainin	g				
	Requirements:						
		shall demonstrate co					
	by scoring 100% or						
	aimed at preventing		inating the				
	need for restrictive						
		shall demonstrate co					
	by scoring a passin		n an				
	instructor training p						
		ng shall be					
	competency-based						
	objectives, measura						
	observation of beha						

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Division of Health Service Regulation

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		mhl041-818	B. WING		F 12/0	R 9/2021
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	12/0	0/2021
SUCCES	SFUL TRANSITIONS	LLC RESIDENTL	DON DRIVE NT, NC 2720			
(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 536	measurable method failing the course. (4) The conteservice provider plate approved by the Dirto Subparagraph (i) (5) Acceptable shall include but are (A) understand (B) methods course; (C) methods performance; and (D) document (6) Trainers steaching a training reducing and eliming interventions at least review by the coach (7) Trainers steaching at preventing need for restrictive annually. (8) Trainers steamed at preventing need for restrictive annually. (8) Trainers steamed at preventing and (j) Service provided documentation of intraining for at least (1) Documentation of instructor (2) The Divis request and review (k) Qualifications of (1) Coaches requirements as a feature of the provided documentation of instructor (2) The Divis request and review (k) Qualifications of (1) Coaches requirements as a feature of the provided documentation of instructor (2) The Divis request and review (k) Qualifications of (1) Coaches requirements as a feature of the provided documentation of the provided documentation of instructor (2) The Divis request and review (k) Qualifications of (1) Coaches requirements as a feature of the provided documentation o	ds to determine passing or ent of the instructor training the ans to employ shall be vision of MH/DD/SAS pursuant (5) of this Rule. le instructor training programs e not limited to presentation of: ding the adult learner; for teaching content of the for evaluating trainee tation procedures. shall have coached experience program aimed at preventing, nating the need for restrictive est one time, with positive n. shall teach a training program g, reducing and eliminating the interventions at least once shall complete a refresher t least every two years. rs shall maintain nitial and refresher instructor three years. mentation shall include: cipated in the training and the l); d where attended; and d's name. ion of MH/DD/SAS may this documentation any time. of Coaches: shall meet all preparation	V 536			

Division of Health Service Regulation

STATE FORM 6899 QRE811 If continuation sheet 7 of 14

Division of Health Service Regulation

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMPI	
			A. BUILDING.		R	,
		mhl041-818	B. WING			9/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
SUCCES	SFUL TRANSITIONS	LLC RESIDENTI.	DON DRIVE			
(V4) ID	SLIMMARY STA	TEMENT OF DEFICIENCIES	NT, NC 2720	PROVIDER'S PLAN OF CORRECTION	ON	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	COMPLETE DATE
V 536	Continued From pa	ge 7	V 536			
	competence by cor train-the-trainer ins	shall demonstrate npletion of coaching or				
	This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure staff (the Licensed Professional (LP)) had completed initial training in alternatives to restrictive interventions. The findings are:					
	the Licensee #1 via - A "Contractor S 3/24/21 with no sign - No evidence the training in alternative	Service Agreement" dated				
	Qualified Professio - The LP's perso the facility but inste company's office) - She was only a	21 and on 12/9/21 with the nal revealed: nnel record was not kept at ad offsite (the parent ble to provide the information nail from the Licensee #1.				

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Division of Health Service Regulation STATE FORM

QRE811 If continuation sheet 8 of 14

DIVISION	of Health Service Re	eguiation					
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER		(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUM	RFK:	A. BUILDING:		COMP	LETED
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		mhl041-818		B. WING			9/2021
NAME OF F			CTDEET AD		STATE, ZIP CODE		
INAIVIE OF F	PROVIDER OR SUPPLIER			, ,	•		
SUCCES	SFUL TRANSITIONS,	LLC RESIDENTI.		DON DRIVE			
			nigh POI	NT, NC 2720			
(X4) ID PREFIX		TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY F	1111	ID PREFIX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU		(X5) COMPLETE
TAG		SC IDENTIFYING INFORMAT		TAG	CROSS-REFERENCED TO THE APPRO		DATE
					DEFICIENCY)		
V 537	Continued From pa	ae 8		V 537			
V 537	27E .0108 Client Rights - Training in Sec Rest &			V 537			
	ITO						
	10A NCAC 27E .01	08 TRAINING IN					
		SICAL RESTRAINT A	ND				
	ISOLATION TIME-0		110				
		sical restraint and isola	ation				
		nployed only by staff w					
	been trained and ha						
	competence in the proper use of and alternatives						
		s. Facilities shall ensu					
		employ and terminate					
		ained and have demo	nstrated				
	competence at leas						
		g direct care to people					
		eatment/habilitation p interventions, staff inc					
		employees, students o	_				
		mplete training in the ເ					
		restraint and isolation					
		ese interventions unti					
		d and competence is					
	demonstrated.	•					
	(c) A pre-requisite	for taking this training	is				
	•	petence by completion					
		ng, reducing and elimir	nating				
	the need for restrict						
		Ill be competency-bas	ed,				
		e learning objectives,	votion of				
		(written and by obser- objectives and measu					
		ne passing or failing t					
	course.	no passing or raining the	110				
		er training must be cor	npleted				
		vider periodically (min					
	annually).	F a.ca) (111111					
		raining that the service)				
		nploy must be approve					
	the Division of MH/I		,				

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If continuation sheet 9 of 14 **QRE811**

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		mhl041-818		B. WING			R 09/2021
	PROVIDER OR SUPPLIER	LLC RESIDENTI	1458 LON	DRESS, CITY, S DON DRIVE NT, NC 2720			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY F SC IDENTIFYING INFORMAT	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
V 537	Paragraph (g) of thi (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 may psychological well-thuse of restrictive interventions which assessment and may psychological well-thuse of restrictive interventions (6) prohibited (7) debriefing importance and pur (8) document (6) prohibited documentation of ir at least three years (1) Document (A) who particulate outcomes (pass/fail (B) when and (C) instructor (2) The Divis review/request this (i) Instructor Qualif Requirements: (1) Trainers is by scoring 100% or	is Rule. ning programs shall ir o, presentation of: information on alternate interventions; is on when to interventioned interventions; on safety and respect all persons involved estrictive interventions; in for the safe implementations; if emergency safety include continuous conitoring of the physic peing of the client and con; if procedures; if strategies, including the procedures; if strategies, including the physic pose; and the training that include: intial and refresher trainitial and	atives to e and et for the (using and entation eal and I the safe of the their dures. ining for and the l; and ay y time.	V 537			

Division of Health Service Regulation

STATE FORM 6899 QRE811 If continuation sheet 10 of 14

DIVISION	of Health Service Re	eguiation					
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPI		(X2) MULTIPL	E CONSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION N	NUMBER:	A. BUILDING:		COMPL	ΕΓED
							
				B. WING		R	
		mhl041-818		J. WINO		12/09	/2021
NAME OF F	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
			1458 I ON	DON DRIVE			
SUCCES	SFUL TRANSITIONS,	, LLC RESIDENTI		_			
			nigh POI	NT, NC 2720	02		
(X4) ID		TEMENT OF DEFICIENC		ID	PROVIDER'S PLAN OF CORRECTI		(X5)
PREFIX TAG		/ MUST BE PRECEDED E SC IDENTIFYING INFORI		PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO		COMPLETE DATE
IAG	ALOGE HORT OR E		W. (11011)	IAG	DEFICIENCY)		
V 537	Continued From pa	ige 10		V 537			
	mand for mantriative	inton continuo					
	need for restrictive						
		shall demonstrate c					
	by scoring 100% or						
	teaching the use of		l restraint				
	and isolation time-c						
		shall demonstrate c					
	by scoring a passin		in an				
	instructor training p	rogram.					
	(4) The training	ng shall be					
	competency-based	, include measurab	le learning				
	objectives, measura	able testing (writter	and by				
	observation of beha	avior) on those obje	ectives and				
	measurable method						
	failing the course.	•	Ü				
		ent of the instructor	training the				
	service provider pla						
	approved by the Div						
	to Subparagraph (j)		to parodant				
		le instructor training	n nrograms				
	shall include, but no						
	of:	or be infinited to, pro-	ocmation				
		ding the adult learr	oer.				
		for teaching conter					
	course;	ior teaching conten	it of the				
		n of trainee perforn	nance, and				
		•	nance, and				
		tation procedures. shall be retrained at	t loost				
	\ /						
	annually and demo						
	of seclusion, physic						
	time-out, as specific	eu in Paragraph (a)) OT THIS				
	Rule.						
		shall be currently tra	ained in				
	CPR.		_				
		shall have coached					
	in teaching the use						
	least two times with	n a positive review b	by the				
	coach.						
		shall teach a progra					
	use of restrictive int						

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE	SURVEY
			A. BUILDING:			
		mhl041-818	B. WING			२ 09/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	STATE, ZIP CODE		
SUCCES	SFUL TRANSITIONS	LLC RESIDENTI.	NDON DRIVE INT, NC 2720			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
V 537	instructor training a (k) Service provide documentation of it training for at least (1) Documer (A) who partic outcome (pass/fail) (B) when and (C) instructo (2) The Divis review/request this (I) Qualifications o (1) Coaches requirements as a (2) Coaches times, the course v (3) Coaches competence by contrain-the-trainer ins	shall complete a refresher at least every two years. ers shall maintain nitial and refresher instructor three years. Intation shall include: cipated in the training and the lipid where they attended; and r's name. Sion of MH/DD/SAS may documentation at any time. If Coaches: shall meet all preparation trainer. It is shall teach at least three which is being coached. It is shall demonstrate mpletion of coaching or truction. In shall be the same	V 537			
	Based on record re failed to ensure sta (LP)) had complete	et as evidenced by: eview and interview, the facility iff (the Licensed Professional ed initial training in seclusion, nd isolation time out. The				
	the Licensee #1 via - A "Contractor \$ 3/24/21 with no sig	Service Agreement" dated				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED							
			A. BUILDING			D							
		mhl041-818	B. WING	·		R 09/2021							
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE													
SUCCESSFUL TRANSITIONS, LLC RESIDENTIA 1458 LONDON DRIVE HIGH POINT, NC 27262													
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE							
V 537	training in seclusion isolation time out w provided by the Lic Interviews on 12/8/Qualified Professio - The LP's persothe facility but instecompany's office) - She was only a	n, physical restraint and vas present in the information ensee #1											
V 736	10A NCAC 27G .03 EXTERIOR REQUI (c) Each facility and maintained in a saf	ity and Grounds Maintenance 303 LOCATION AND IREMENTS d its grounds shall be fe, clean, attractive and order be kept free from offensive											
	Based on observating failed to maintain the and orderly manner Observation on 12/10:30 am and 3:10 (a) Client #1 and # - A hole in wall and the angle of the ang	/8/21 of the facility between pm revealed: #2's bedroom bove client #1's bed											

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED							
mhl041-818		B. WING			R 12/09/2021							
NAME OF PROVIDER OR SUPPLIER SUCCESSFUL TRANSITIONS, LLC RESIDENTI 1458 LONDON DRIVE HIGH POINT, NC 27262												
(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 (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE					
V 736	(c) Activity room - Linoleum floorir steps leading into th - A dented metal heating/cooling ven - The sides of the separated and was right side of the duc. Interview on 12/9/2 Professional (AP) ro - Depending on the completed, either repairs himself or hwork. Interview on 12/9/2 Professional reveal - Confirmation of the surveyor.	ng not fully attached the activity room stack duct with a t located at the top of e metal stack duct hat open along the seament. I with the Associate evealed: he type of work that iter the Licensee #2 maired someone to com I with the Qualified ed: what the AP had repositives a re-cited definition.	f the duct ad as on the meeded to ade the aplete the corted to	V 736								

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