AND PLAN OF CORRECTION				IPLE CONSTRUCTION         (X3           IG:		3) DATE SURVEY COMPLETED	
		mhl011-087	B. WING		12	/16/2021	
NAME OF PF	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE,	, ZIP CODE			
	EK		OK DRIVE LLE, NC 28805				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLET DATE	
V 000	INITIAL COMMENTS		V 000				
		-up survey was completed 21. Deficiencies were cited.					
	category: 10A NCAC	d for the following service 27G.5600C Supervised Developmental Disability.					
V 536	27E .0107 Client Rig Int.	nts - Training on Alt to Rest.	V 536				
	to restrictive intervent (b) Prior to providing disabilities, staff inclu employees, students demonstrate competer completing training in other strategies for cr	RESTRICTIVE plement policies and size the use of alternatives tions. services to people with ding service providers, or volunteers, shall ence by successfully communication skills and reating an environment in					
	or injury to a person or property damage is p (c) Provider agencies based on state comp	of imminent danger of abuse with disabilities or others or revented. s shall establish training etencies, monitor for internal onstrate they acted on data					
	(d) The training shall include measurable le measurable testing (v behavior) on those of	be competency-based, earning objectives, written and by observation of ojectives and measurable e passing or failing the					
	.,	training must be completed der periodically (minimum					

STATE FORM

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		mhl011-087	B. WING		12	2/16/2021
NAME OF P	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE,	ZIP CODE		
HAW CRE	EK		OK DRIVE LLE, NC 28805			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETI DATE
V 536	Continued From page	e 1	V 536			
	the Division of MH/DI Paragraph (g) of this (g) Staff shall demon following core areas: (1) knowledge people being served; (2) recognizing behavior; (3) recognizing external stressors that disabilities; (4) strategies for relationships with per (5) recognizing organizational factors disabilities; (6) recognizing assisting in the perso decisions about their (7) skills in ass escalating behavior; (8) communica and de-escalating por and (9) positive beh means for people with activities which direct behaviors which are of (h) Service providers documentation of initi at least three years. (1) Documenta (A) who particip outcomes (pass/fail); (B) when and w (C) instructor's (2) The Division	Rule. Instrate competence in the and understanding of the and interpreting human the effect of internal and at may affect people with or building positive sons with disabilities; cultural, environmental and that may affect people with the importance of and n's involvement in making life; essing individual risk for tion strategies for defusing tentially dangerous behavior; navioral supports (providing h disabilities to choose dy oppose or replace unsafe). shall maintain ial and refresher training for tion shall include: nated in the training and the where they attended; and				

	FOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			SURVEY PLETED	
					40	2/16/2021	
	ROVIDER OR SUPPLIER	mhl011-087	DDRESS, CITY, STATE		12	/16/2021	
		15 BRO0	OK DRIVE				
IAW CRE	EK	ASHEVI	LLE, NC 28805				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A) CROSS-REFERENCED TO DEFICIE!	CTION SHOULD BE ) THE APPROPRIATE	(X5) COMPLE DATE	
V 536	Continued From pag	e 2	V 536				
	by scoring 100% on aimed at preventing, need for restrictive ir (2) Trainers sh by scoring a passing instructor training pro (3) The trainin competency-based, objectives, measural observation of behave measurable methods failing the course. (4) The conter service provider plan approved by the Divit to Subparagraph (i)( (5) Acceptable shall include but are (A) understand (B) methods for course; (C) methods for performance; and (D) documenta (6) Trainers sh teaching a training p reducing and elimina interventions at least review by the coach. (7) Trainers sh aimed at preventing,	hall demonstrate competence testing in a training program reducing and eliminating the interventions. hall demonstrate competence grade on testing in an ogram. g shall be include measurable learning ble testing (written and by vior) on those objectives and is to determine passing or ht of the instructor training the his to employ shall be ision of MH/DD/SAS pursuant 5) of this Rule. instructor training programs not limited to presentation of: ing the adult learner; or teaching content of the for evaluating trainee tion procedures. hall have coached experience rogram aimed at preventing, ating the need for restrictive t one time, with positive hall teach a training program reducing and eliminating the					
	need for restrictive ir annually. (8) Trainers sh	nterventions at least once nall complete a refresher least every two years.					

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:	DNSTRUCTION		E SURVEY IPLETED
		mhl011-087	•		12	2/16/2021
NAME OF PI	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE,	, ZIP CODE		
HAW CRE	EK		OK DRIVE LLE, NC 28805			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 536	Continued From page	e 3	V 536			
	facility failed to ensur training in alternative	as evidenced by: ew and interviews, the e that all staff completed s to restrictive intervention rrent staff audited (Staff #1).				
	revealed: -Hired on 4/13/20 as Professional Live-in. -Approved training or	of Staff #1's employee file a Direct Support n alternatives to restrictive completed on 4/15/20 and				

STATE FORM

STATEMEN	of Health Service Regure FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:	ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		mhl011-087	B. WING		12	/16/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
HAW CRE	EK					
			LE, NC 28805			
(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 DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
V 536	Continued From page	9 4	V 536			
	expired 4/14/21.					
	Human Resources Co -The NCI+ certificate	of an e-mail sent by the pordinator revealed: expiring on 4/14/21 was Staff #1's Human Resource				
	-She now worked at t to cover on the weeke -The last time she wo in December - 12/3/2 -She was notified today	rked was the first weekend				
V 537	27E .0108 Client Righ ITO	nts - Training in Sec Rest &	V 537			
	ISOLATION TIME-OU (a) Seclusion, physic time-out may be emp been trained and hav competence in the pri- to these procedures. staff authorized to em- procedures are retrain competence at least a (b) Prior to providing of disabilities whose treat includes restrictive int service providers, em- volunteers shall comp seclusion, physical retrained	CAL RESTRAINT AND JT al restraint and isolation loyed only by staff who have e demonstrated oper use of and alternatives Facilities shall ensure that uploy and terminate these hed and have demonstrated annually. direct care to people with atment/habilitation plan terventions, staff including ployees, students or olete training in the use of straint and isolation time-out se interventions until the				

Division of Health Service Regulation STATE FORM

6899

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		mhl011-087	B. WING		12	2/16/2021
NAME OF PF	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE,	ZIP CODE		
HAW CRE	ЕК		OK DRIVE LLE, NC 28805			
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	THE APPROPRIATE	COMPLETI DATE
V 537	Continued From page	e 5	V 537			
	demonstrated.					
		r taking this training is				
		etence by completion of				
		, reducing and eliminating				
	the need for restrictiv					
		(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 plans to employ must be approved by					
	the Division of MH/DI	D/SAS pursuant to				
	Paragraph (g) of this					
		ng programs shall include,				
	but are not limited to,	-				
	(1) refresher in the use of restrictive	formation on alternatives to interventions;				
	(2) guidelines of	on when to intervene				
		nent danger to self and				
		on safety and respect for the				
	• •	all persons involved (using				
		trictive interventions and				
	incremental steps in a					
		or the safe implementation				
	of restrictive interven	-				
	(5) the use of e	emergency safety				
	interventions which ir	nclude continuous				
		nitoring of the physical and				
		eing of the client and the safe				
		ghout the duration of the				
	restrictive intervention					
	(6) prohibited p					
	(7) debriefing s	strategies, including their				1

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED
			A. BUILDING:			
		mhl011-087	B. WING		12	2/16/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET	DDRESS, CITY, STATE,	, ZIP CODE		
HAW CRE	EK					
			LLE, NC 28805			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE
V 537	Continued From page	e 6	V 537			
	importance and purpo	ose: and				
		tion methods/procedures.				
	(h) Service providers					
	()	ial and refresher training for				
	at least three years.					
	-	tion shall include:				
	<ul><li>(A) who participated in the training and the outcomes (pass/fail);</li></ul>					
		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 Qualification and Training					
	Requirements:					
	(1) Trainers shall demonstrate competence					
	by scoring 100% on testing in a training program					
		reducing and eliminating the				
	need for restrictive in					
	(2) Trainers sha	all demonstrate competence				
		esting in a training program				
	teaching the use of seclusion, physical restraint					
	and isolation time-out	t.				
	(3) Trainers sha	all demonstrate competence				
	by scoring a passing	grade on testing in an				
	instructor training pro	ogram.				
	(4) The training shall be					
	competency-based, in	nclude measurable learning				
	objectives, measurab	ble testing (written and by				
	observation of behav	ior) on those objectives and				
		to determine passing or				
	failing the course.					
	( )	t of the instructor training the				
	service provider plans					
		sion of MH/DD/SAS pursuant				
	to Subparagraph (j)(6	-				
		instructor training programs				
		be limited to, presentation				
	of:	ing the adult learner;				
	(A) understandi					

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING:			E SURVEY PLETED
	ROVIDER OR SUPPLIER	mhl011-087	ADDRESS, CITY, STATE,		12	2/16/2021
			OK DRIVE			
HAW CRE	EK		LLE, NC 28805			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OI (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 537	Continued From page	e 7	V 537			
	(B) methods fo course:	r teaching content of the				
	,	of trainee performance; and				
	(D) documentat	ion procedures.				
	(.)	all be retrained at least				
	annually and demonstrate competence in the use					
	of seclusion, physical restraint and isolation					
	time-out, as specified in Paragraph (a) of this Rule.					
	<ul><li>(8) Trainers shall be currently trained in CPR.</li></ul>					
	(9) Trainers shall have coached experience					
	in teaching the use of restrictive interventions at					
	least two times with a positive review by the					
	coach.					
	(10) Trainers shall teach a program on the use of restrictive interventions at least once					
	annually.					
		all complete a refresher				
	-	east every two years.				
	(k) Service providers shall maintain					
	documentation of initial and refresher instructor training for at least three years.					
		tion shall include:				
		pated in the training and the				
	outcome (pass/fail);	5				
		where they attended; and				
	(C) instructor's					
		n of MH/DD/SAS may				
	-	ocumentation at any time.				
	(I) Qualifications of C					
	(1) Coaches sh requirements as a tra	nall meet all preparation				
		nall teach at least three				
	times, the course whi					
		nall demonstrate				
	competence by comp					
	train-the-trainer instru					
	(m) Documentation s	shall be the same				

of Health Service Regu OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED			
	mhl011-087	B. WING		12	/16/2021			
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE  HAW CREEK  AUGUSTICATION OF A DOLUTION OF A DO								
EK								
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO	TION SHOULD BE	(X5) COMPLET DATE			
Continued From page	e 8	V 537						
preparation as for tra	iners.							
Based on record revia facility failed to ensure training in seclusion, isolation time-out and audited (Staff #1). The Review on 12/16/21 of revealed: -Hired on 4/13/20 as Professional Live-in. -Approved training or and isolation time-out 4/15/20 and expired of Review on 12/16/21 of Human Resources C -The NCI+ certificate everything she had in file.	ew and interviews, the e that all staff completed physical restraint and nually for 1 of 3 current staff he findings are: of Staff #1's employee file a Direct Support n seclusion, physical restraint t (NCI+) completed on 4/14/21. of an e-mail sent by the oordinator revealed: expiring on 4/14/21 was n Staff #1's Human Resource							
-She now worked at t to cover on the week -The last time she wo in December - 12/3/2 -She was notified tod	the facility PRN and helped ends. orked was the first weekend 1 - 12/6/21. ay her NCI+ training had							
	Review on 12/16/21 of Review on 12/16/21 of Human Resources C -The NCI+ certificate everything she had in file.	IDENTIFICATION NUMBER:         mhl011-087         ROVIDER OR SUPPLIER       STREET A         EK       15 BRO ASHEVII         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         Continued From page 8 preparation as for trainers.         This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to ensure that all staff completed training in seclusion, physical restraint and isolation time-out annually for 1 of 3 current staff audited (Staff #1). The findings are:         Review on 12/16/21 of Staff #1's employee file revealed: -Hired on 4/13/20 as a Direct Support Professional Live-in. -Approved training on seclusion, physical restraint and isolation time-out (NCI+) completed on 4/15/20 and expired 4/14/21.         Review on 12/16/21 of an e-mail sent by the Human Resources Coordinator revealed: -The NCI+ certificate expiring on 4/14/21 was everything she had in Staff #1's Human Resource file.         Interview on 12/16/21 with Staff #1 revealed: -She now worked at the facility PRN and helped to cover on the weekends. -The last time she worked was the first weekend in December - 12/3/21 - 12/6/21. -She was notified today her NCI+ training had expired and planned to re-take it as soon as	IDENTIFICATION NUMBER:       A. BUILDING:         mh1011-087       B. WING         ROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE         SUMMARY STATEMENT OF DEFICIENCIES       10         PREFIX       REQULATORY OR LSC IDENTIFYING INFORMATION)       PREFIX         TAG       V 537         Continued From page 8       V 537         preparation as for trainers.       V 537         This Rule is not met as evidenced by:       Based on record review and interviews, the facility failed to ensure that all staff completed training in seclusion, physical restraint and isolation time-out annually for 1 of 3 current staff audited (Staff #1). The findings are:         Review on 12/16/21 of Staff #1's employee file revealed:       -Hired on 4/13/20 as a Direct Support         -Hired on 4/13/20 as a Direct Support       Professional Live-in.         -Approved training on seclusion, physical restraint and isolation time-out (NCI+) completed on 4/15/20 and expired 4/14/21.         Review on 12/16/21 of an e-mail sent by the Human Resources Coordinator revealed:         -The NCI+ certificate expiring on 4/14/21 was everything she had in Staff #1's Human Resource file.         Interview on 12/16/21 with Staff #1 revealed:         -She now worked at the facility PRN and helped to cover on the weekends.         -The last time she worked was the first weekend in December - 12/3/21 - 12/6/21.         She was notified today her NCI+ training had expired and	F CORRECTION       IDENTIFICATION NUMBER: mh1011-087       A BUILDING: B WING         MOUDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE         SUMMARY STATEMENT OF DEFICIENCIES (RACH CORRECTIVE ASHEVILLE, NC 28805       ID PROVIDER'S PLAN O (RACH CORRECTIVE ASHEVILLE, NC 28805         Continued From page 8 preparation as for trainers.       ID PREFX Tag       PROVIDER'S PLAN O (RACH CORRECTIVE A CROSS-REFERENCED TO DEFICIEN         This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to ensure that all staff completed training in seclusion, physical restraint and isolation time-out annually for 1 of 3 current staff audited (Staff #1). The findings are: Review on 12/16/21 of Staff #1's employee file revealed: -Hired on 4/13/20 as a Direct Support Professional Live-in. -Approved training on seclusion, physical restraint and isolation time-out (NCH) completed on 4/15/20 and expired 4/14/21.         Review on 12/16/21 of an e-mail sent by the Human Resources Coordinator revealed: -The NCH certificate expiring on 4/14/21 was everything she had in Staff #1's Human Resource file.         Interview on 12/16/21 with Staff #1 revealed: -She now worked at the facility PRN and helped to cover on the weekends. -The last time she worked was the first weekend in December - 12/3/21 - 12/6/21.	F CORRECTION       IDENTIFICATION NUMBER:       A BUILDING:			