STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL043-075	A. BUILDING: _____ B. WING _____	R 12/16/2021

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V 512	Continued From page 30 on 10/11/21 during the early morning hours from 12am to 2:30am. [FC #A6] said [FS #11] came in her bedroom and hit her with a plastic clothes hanger on the back, head and legs while she was in the bed and turn down on her side and face. [FC #A6] also reported [FS #11] picked up her blue tennis shoe from the floor and hit her with the tennis shoe. [Staff #A14] discovered the injuries on [FC #A6] at [sister facility] while assisted her during the wake-up routine and reported it to her co-worker [staff #A13] on 10/13/21. [Staff #13] noticed the injuries at the [day program] and called her supervisor (DOO/QP #1)...Conclusion: neglect was substantiated as staff [FS #11] failed to implement less intrusive NCI (National Crisis Intervention) techniques and failed to follow NCI interventions to address client [FC #A6] disruptive behaviors. Physical Abuse was substantiated as staff [FS #11] hit [FC #A6] with a white plastic clothes hanger and hit her with the member's blue tennis shoe as well. Final Disposition/Recommendations: 1. staff [FS #11] was terminated for client rights violations of physical abuse and neglect 2. The Director of Quality Management will provide additonal refresher training to Harmony Home staff on Abuse, Neglect Prevention..." Review on 12/13/21 of a police incident/investigation report for FC #A6 revealed: - "on 10/15/21 at approximately 1448 (2:48pm)...was given information regarding an assault...was given information to call the [DQM] regarding the incident...a caregiver [FS #11] assaulted [FC #A6]. [FS #11] assaulted [FC #A6] by striking her on her head, arms and legs with a coat hanger and a shoe...[DQM] stated that [FC #A6] does not reside at the Dunn location and was just there because of an issue with her	V 512		

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V 512	Continued From page 31 permeant room at the [Sister Facility A] location... [DQM] also confirmed that [FC #A6] was of sound mind and was able to recall the incident with clarity..." Review on 12/13/21 of a medical summary from FC #A6's primary physician revealed: - appointment date 10/14/21 - "...patient reported that she had to stay at a different facility and reported that the staff there was physically abusive. She reported bruising...she reports that an employee hit her and that she has bruising...reports a shoe and clothes hanger was used...skin inspection and palpation: lesion (ecchymosis in various areas) 1. back of neck, posterior scale 3. left upper thorax 4. left lateral upper thigh (2) 5. right medial lower leg 6. left inner upper thigh...Assessment/Plan...Physical abuse of elderly person reported in a patient with intellectual disability that is able to give a concise HPI (history of present illness)..." Interview on 12/13/21 FC #A6 reported: - confirmed she was hit with a clothes hanger by FS #11 while at Harmony Home - happened one time - it was at night and there were no witnesses - bruises on her legs "and everywhere" - tried to walk away from the facility after the incident - FS #11 requested she return to the facility - the 10/11/21 incident made her "feel bad" Interview on 12/10/21 FS #11 reported: - received a call from staff #10 - staff #10 cried and reported FC #A6 had behaviors - she (FS #11) had just left the facility and told staff #10 she was tired	V 512		

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V 512	Continued From page 32 - staff #10 said the DOO/QP#1 requested she return to work - FC #A6 was in her bedroom when she arrived and was cussing - tried to ignore when she cussed - she heard a loud bang - had a clothes hanger hitting a glass on the dresser, threatened to break her car windows, threatened to set facility on fire and burn up the clients & threatened to kill her mother - tried to spit on her and hit her (FS #11) - kicked the furniture and kicked "wildly" with her arms, threw herself on the floor and fell backwards - stayed with her in the bedroom until she calmed down - later, heard the door alarm, when she (FS #11) got to the door, she (FS #A6) was not far and she redirected her to return to the facility - did not call anyone about the behaviors because she could not find her phone - she helped her get dressed the next morning and there were no bruises Interview on 12/14/21 the DQM reported: - he inserviced staff at Sister Facility A on abuse/neglect - QP #2 will provide abuse/neglect training for Harmony Home staff - he reviewed the abuse/neglect curriculum with QP #2 - QP #2 scheduled an inservice abuse/neglect training with staff today (12/14/21) Review on 12/16/21 of the facility's Plan of Protection dated 12/16/21 submitted by the DOO/QP #1 revealed: - "What immediate action will the facility take to ensure the safety of the consumers in your care?	V 512		

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V 512	Continued From page 33 An investigation was conducted and completed and staff terminated prior to the survey An IRIS (Incident Response Improvement System) report was completed and appropriate notifications took place and the investigation findings were shared in a timely manner Before the survey was completed the QP provided training to Harmony Home staff on abuse neglect prevention and the in-service was presented during the survey The QP will monitor in the home daily to ensure that the client are protected from abuse Neglect and exploitation The Director of Quality management will monitor weekly to ensure that clients are protected from Abuse neglect and exploitation The management team will meet weekly to discuss any client right violations to ensure they are protected from any harm, abuse, neglect or exploitation - Describe your plans to make sure the above happens. The QP [name from day program], PhD will meet with the management team weekly to determine the status of any Corrective actions to ensure compliance" FC #A6 had diagnoses of Bipolar Disorder with dependent Personality Disorder & Mild Intellectual Developmental Disorder. There was a treatment plan with behaviors that consisted of verbal aggression, making threats to harm others, kicking and biting. She was at Harmony Home due to lack of staff at Sister Facility A, where she resided at. A facility's investigation completed by the DQM documented FC #A6 said FS #11 came in her bedroom and hit her with a plastic clothes hanger on the back, head and legs while she was in the bed and turned down on her side and face.	V 512		

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V 512	Continued From page 34 A medical summary documented elderly abuse due to bruises to the legs, neck and back of FC #A6. FS #11 was terminated & the DQM recommended additional refresher training on abuse & neglect prevention. The DQM provided Sister Facility A's staff with the refresher training, however, Harmony Home's staff was provided the abuse & prevention training 2 months after the incident happened. The training was provided during the course of the survey on 12/14/21 by QP#2. This deficiency constitutes a Type A1 rule violation for serious abuse and must be corrected within 23 days. An administrative penalty of $1,000 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 512		
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	V 536		

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V 536	Continued From page 35 compliance and demonstrate they acted on data gathered. (d) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (e) Formal refresher training must be completed by each service provider periodically (minimum annually). (f) Content of the training that the service provider wishes to employ must be approved by the Division of MH/DD/SAS pursuant to Paragraph (g) of this Rule. (g) Staff shall demonstrate competence in the following core areas: (1) knowledge and understanding of the people being served; (2) recognizing and interpreting human behavior; (3) recognizing the effect of internal and external stressors that may affect people with disabilities; (4) strategies for building positive relationships with persons with disabilities; (5) recognizing cultural, environmental and 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	V 536	The facility will review its policy and procedures on training relative to alternatives to restrictive interventions and provide updates accordingly. The Quality Management Director will coordinate with the EBPI instructor towards the modifications to the policy. The facility reserves the right as outlined in the rules to have staff trained in either and to implement training for EBPI and/or NCI Plus. The staff will be in-service by the QP and/or EBPI Instructor on updates to the policy to reflect the use of alternatives to restrictive interventions. The Director of Quality Management will consult with EBPI Instructor quarterly should there be a need to update the policy to reflect the use of alternatives to restrictive interventions. As changes occur to the policy, staff will be in-service accordingly on any updates.	2/14/22 2/14/22 2/14/22 2/14/22

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V 536	Continued From page 36 activities which directly oppose or replace behaviors which are unsafe). (h) Service providers shall maintain documentation of initial and refresher training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcomes (pass/fail); (B) when and where they attended; and (C) instructor's name; (2) The Division of MH/DD/SAS may review/request this documentation at any time. (i) Instructor Qualifications and Training Requirements: (1) Trainers shall demonstrate competence by scoring 100% on testing in a training program aimed at preventing, reducing and eliminating the need for restrictive interventions. (2) Trainers shall demonstrate competence by scoring a passing grade on testing in an instructor training program. (3) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (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.	V 536		

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V 536	Continued From page 37 (6) Trainers shall have coached experience teaching a training program aimed at preventing, reducing and eliminating the need for restrictive interventions at least one time, with positive review by the coach. (7) Trainers shall teach a training program aimed at preventing, reducing and eliminating the need for restrictive interventions at least once annually. (8) Trainers shall complete a refresher instructor training at least every two years. (j) Service providers shall maintain documentation of initial and refresher instructor training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcomes (pass/fail); (B) when and where attended; and (C) instructor's name. (2) The Division of MH/DD/SAS may request and review this documentation any time. (k) Qualifications of Coaches: (1) Coaches shall meet all preparation requirements as a trainer. (2) Coaches shall teach at least three times the course which is being coached. (3) Coaches shall demonstrate 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:	V 536		

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V 536	Continued From page 38 Based on record review and interview, the facility failed to implement policies and practices that emphasize the use of alternatives to restrictive interventions for 4 of 4 staff (#8-#10 and Qualified Professional #2) and 1 of 1 former staff (FS #11). The findings are: Review on 12/2/21 of the facility's records revealed the following: - policy on alternatives to restrictive interventions did not specify which program would be utilized - training packet for Evidence Based Prevention Intervention (EBPI) Interviews between 12/2/21 and 12/14/21, the Human Resources Manager and the Director of Quality Management (DQM) reported the facility utilized the National Crisis Intervention (NCI) curriculum for therapeutic interventions I. Example of utilization of different training content programs a. Review on 12/2/21 of staff #9's personnel record revealed: - hired: 3/19/13 - certificate for EBPI dated 6/12/20 with an expiration date of 7/1/21 Review on 12/7/21 of a fax dated 12/6/21 received from the Human Resources Manager revealed: - staff #9's certificate for EBPI dated 6/11/21 with an expiration date of one year b. Review on 12/2/21 of staff #8's personnel record revealed: - hired: 11/3/16 - certificate for EBPI dated 11/17/21	V 536		

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V 536	Continued From page 39 c.Review on 12/7/21 of the Qualified Professional (QP) #2's personnel record revealed: - hired: 8/9/21 - certificate for EBPI Plus dated 7/30/21 with a one year expiration date Interview on 12/3/21, the QP #2 reported: - he was trained in NCI by the agency d. Review on 12/2/21 of staff #3's personnel record revealed: - hired: 6/9/21 - certificate for NCI dated 6/18/21 with a one year expiration date e. Review on 12/13/21 of FS #11's record revealed: - hired: 10/1/20 - terminated: 11/2/21 - certificate for EBPI Plus dated 9/10/21 with a one year expiration date Interview on 12/14/21 the Director of Operations (DOO)/QP #1 reported: - EBPI was used by the agency for a couple of years - Human Resources reviewed the staff records quarterly/every 6 months. - not aware of someone trained in something else- NCI. - if a staff was hired and was trained in another program, the agency would accept that program. Once their certification expired, the staff would be trained in EBPI. - she was unsure if the staff #10 was trained prior to her hire date or by the facility's instructor. Interview on 12/8/21 the developer of NCI	V 536		

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V 536	Continued From page 40 reported: - whenever asked if the facility could utilize multiple programs, "I urge them not to." - the facility should have the NCI program specified in their policies. Interview on 12/8/21 the developer of EBPI reported: - facility should have it in their policy and procedure they will utilize EBPI II. Example of staff reported recertification expired and facility reported training as current. Review on 12/13/21 of FS #11's record revealed: - certificate for EBPI Plus dated 9/10/21 with a one year expiration date - "corrective action" dated 10/15/21 issued by the facility to staff due to violation of NCI techniques and client rights Interview on 12/9/21, FS #11 reported: - due to staffing shortages, she was not recertified in alternatives to restrictive interventions. - the day she was scheduled to attend, the DOO/QP #1 wanted her to work and informed the instructor to reschedule - prior to her termination, she was not recertified in alternatives to restrictive interventions - management (DOO/QP#1 and DQM) had "always emphasized, if you were not trained ..do not put your hands on these people" - she was terminated due to an incident on 10/11/21. She did not sign the correction action because she did not agree with it. Interview on 12/2/21 with the Human Resources Director revealed:	V 536		

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V 536	Continued From page 41 - verified trainings in the records were the most current III. Example of Instructor's failure to demonstrate skills Interview on 12/2/21 the Human Resources Director reported: - EBPI and NCI Plus were the same Interview on 12/8/21, the facility's trainer for alternatives for restrictive interventions revealed: - certified to train both EBPI and NCI Plus - EBPI and NCI Plus were the same except for language Interview on 12/3/21 the developer of EBPI reported: - verified EBPI and NCI Plus had different content of training material and product objectives - EBPI utilized three different types of trainings. - EBPI prevent was the de-escalation portion of the training. - EBPI prevent would be considered the equivalent of alternatives to restrictive interventions - agencies should have which curriculum they use in their policy Interview on 12/8/21 the developer of NCI reported: - NCI took the prevention piece and made it best practices - NCI included trauma care in the content of their training. Interview on 12/14/21 the DQM reported: - if staff were trained in an approved intervention then" it would still be okay to work." - if the staff's "certificates were within	V 536		

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V 536	Continued From page 42 compliance, then that person should be qualified" for restrictive interventions. - he would need to examine content of both trainings to see if they were the same. Interview on 12/9/21 the North Carolina Division of Mental Health Legislative and Regulatory Affairs Team: - "There is no requirement in rule that prevents a provider from having staff trained in different alternative and restrictive intervention curricula. - Each curriculum must be approved. - The approval process determined that the curriculum met the rule requirements in 10A NCAC 27E .0107 and/or .0108. - No two curricula are the same however each curriculum was determined to meet each of the rule requirements. - Subtle nuances in each curriculum may train staff differently in implementing an intervention. - It may be confusing to the service recipient when all staff do not follow the same protocols..."	V 536		
V 537	27E .0108 Client Rights - Training in Sec Rest & ITO 10A NCAC 27E .0108 TRAINING IN SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT (a)Seclusion, physical restraint and isolation time-out may be employed only by staff who have been trained and have demonstrated competence in the proper use of and alternatives to these procedures. Facilities shall ensure that staff authorized to employ and terminate these procedures are retrained and have demonstrated competence at least annually. (b)Prior to providing direct care to people with disabilities whose treatment/habilitation plan	V 537		

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V 537	Continued From page 43 includes restrictive interventions, staff including service providers, employees, students or volunteers shall complete training in the use of seclusion, physical restraint and isolation time-out and shall not use these interventions until the training is completed and competence is demonstrated. (c) A pre-requisite for taking this training is demonstrating competence by completion of training in preventing, reducing and eliminating the need for restrictive interventions. (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/DD/SAS pursuant to Paragraph (g) of this Rule. (g) Acceptable training programs shall include, but are not limited to, presentation of: (1) refresher information on alternatives to the use of restrictive interventions; (2) guidelines on when to intervene (understanding imminent danger to self and others); (3) emphasis on safety and respect for the rights and dignity of all persons involved (using concepts of least restrictive interventions and incremental steps in an intervention); (4) strategies for the safe implementation of restrictive interventions; (5) the use of emergency safety interventions which include continuous	V 537		

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V 537	Continued From page 44 assessment and monitoring of the physical and psychological well-being of the client and the safe use of restraint throughout the duration of the restrictive intervention; (6) prohibited procedures; (7) debriefing strategies, including their importance and purpose; and (8) documentation methods/procedures. (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 Qualification 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 100% on testing in a training program teaching the use of seclusion, physical restraint and isolation time-out. (3) Trainers shall demonstrate competence by scoring a passing grade on testing in an instructor training program. (4) 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. (5) The content of the instructor training the service provider plans to employ shall be	V 537		

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V 537	Continued From page 45 approved by the Division of MH/DD/SAS pursuant to Subparagraph (j)(6) of this Rule. (6) Acceptable instructor training programs shall include, but not be limited to, presentation of: (A) understanding the adult learner; (B) methods for teaching content of the course; (C) evaluation of trainee performance; and (D) documentation procedures. (7) Trainers shall 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. (8) Trainers shall be currently trained in CPR. (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. (11) Trainers shall complete a refresher instructor training at least every two years. (k) 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 outcome (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. (l) Qualifications of Coaches: (1) Coaches shall meet all preparation requirements as a trainer.	V 537		

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V 537	Continued From page 46 (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. (m) Documentation shall be the same preparation as for trainers. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to implement policies and practices that emphasize the use of Seclusion, Physical Restraint and Isolation Time Out for 4 of 4 current staff (#1-#3 and Qualified Professional #2) and 1 of 1 former staff (FS #11). The findings are: Review on 12/2/21 of the facility's records revealed the following: - policy on Seclusion, Physical Restraint and Isolation Time Out did not specify which program would be utilized - training packet for Evidence Based Prevention Intervention (EBPI) I. Example of utilization of different training content programs a. Review on 12/2/21 of staff #9's personnel record revealed: - hired: 3/19/13 - certificate for EBPI Base Plus dated 6/12/20 with an expiration date of 7/1/21 Review on 12/7/21 of a fax dated 12/6/21 received from the Human Resource Manager revealed:	V 537	The facility will implement policies and procedures concerning its use of physical restraints, seclusion and Time Out to include but not limed to annual and updated staff training as needed, or as required. The Quality Management Director will coordinate with the EBPI Instructor and Training Coordinator to ensure that EBPI and/or NCI Plus training on all staff is brought up-to-date and kept current, per facility policy. The facility reserves the right as outlined in the rules to have staff trained in either and to implement training for EBPI and/or NCI Plus. . The Director of Quality Management will consult with the EBPI Instructor and facility Training Coordinator on a quarterly basis to ensure that 100% of staff have updated training and certificates for the same on file.	2/14/22 2/14/22 2/14/22 2/14/22

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V 537	Continued From page 47 - staff #9's certificate for EBPI Base Plus dated 6/11/21 with an expiration date of one year expiration date b. Review on 12/2/21 of staff #8's personnel record revealed: - hired: 11/3/16 - certificate for EBPI Base Plus dated 11/17/21 c. Review on 12/7/21 of the Qualified Professional (QP) #2's personnel record revealed: - hired: 8/9/21 - certificate for EBPI Base Plus dated 7/30/21 with a one year expiration date Interview on 12/3/21, the QP #2 reported: - he was trained in NCI by the agency d. Review on 12/2/21 of staff #10's personnel record revealed: - hired: 6/9/21 - certificate for NCI Plus dated 6/18/21 with a one year expiration date e. Review on 12/13/21 of FS #11's record revealed: - hired: 10/1/20 - terminated: 11/2/21 - certificate for EBPI Base Plus dated 9/10/21 with a one year expiration date Interview on 12/14/21 the Director of Operations (DOO)/QP #1 reported: - EBPI was used by the agency for a couple of years - Human Resources reviewed the staff records quarterly/every 6 months. - Not aware of someone trained in something else- NCI plus.	V 537		

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V 537	Continued From page 48 - If a staff was hired and was trained in another program, the agency would accept that program. Once their certification expired, the staff would be trained in EBPI Base Plus. - She was unsure if the staff #10 was trained prior to her hire date or by the facility's instructor. Interview on 12/8/21 the developer of NCI reported: - Whenever asked if the facility could utilize multiple programs, "I urge them not to." - The facility should have in their policy NCI as their program for seclusion, physical restraint and isolation time out Interview on 12/8/21 the developer of EBPI reported: - Facility should have it in their policy and procedure they will utilize EBPI plus II. Example of staff reported recertification expired and facility reported training as current. Review on 12/13/21 of FS #11's record revealed: - certificate for EBPI Base Plus dated 9/10/21 with a one year expiration date - "corrective action" dated 10/15/21 issued by the facility to staff due to violation of NCI techniques and client rights Interview on 12/9/21, FS #11 reported: - due to staffing shortages, she was not re-certified in alternatives to restrictive interventions. - the day she was scheduled to attend, the DOO/QP #1 wanted her to work and informed the instructor to reschedule - prior to her termination, she was not re-certified in alternatives to restrictive interventions	V 537		

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V 537	Continued From page 49 - management (DOO/QP#1 and Director of Quality Management (DQM) had "always emphasized, if you were not trained ..do not put your hands on these people" - she was terminated due to an incident on 10/11/21. She did not sign the "correction action" because she did not agree with it. Interview on 12/2/21 with the Human Resources Director revealed: - verified trainings in the records were the most current III. Example of Instructor's failure to demonstrate skills Interview on 12/2/21 the Human Resources Director reported: - EBPI Base Plus and NCI Plus were the same Interview on 12/8/21, the facility's trainer for alternatives for restrictive interventions revealed: - certified to train both EBPI Base Plus and NCI Plus - EBPI Base Plus and NCI Plus were the same except for language Interview on 12/3/21 the developer of EBPI reported: - verified EBPI and NCI Plus had different content of training material and product objectives - EBPI utilized three different types of trainings. - EBPI Base meant only the simple blocks, complex holds and alternative to restrictive interventions would be included in the curriculum - EBPI Base Plus included trainings for alternative to restrictive interventions, base and also options such as restraints, walks and transports. - agencies should have which content of	V 537		

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V 537	Continued From page 50 training program they use in their policy Interview on 12/14/21 the DQM reported: - if staff were trained in an approved intervention then "it would still be okay to work." - if the staff's "certificates were within compliance, then that person should be qualified" for restricitve intervntions. - he would need to examine content of both trainings to see if they were the same. Interview on 12/9/21 the North Carolina Division of Mental Health Legislative and Regulatory Affairs Team: - "There is no requirement in rule that prevents a provider from having staff trained in different alternative and restrictive intervention curricula. - Each curriculum must be approved. - The approval process determined that the curriculum met the rule requirements in 10A NCAC 27E .0107 and/or .0108. - No two curricula are the same however each curriculum was determined to meet each of the rule requirements. - Subtle nuances in each curriculum may train staff differently in implementing an intervention. - It may be confusing to the service recipient when all staff do not follow the same protocols..."	V 537		
V 736	27G .0303(c) Facility and Grounds Maintenance 10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS (c) Each facility and its grounds shall be maintained in a safe, clean, attractive and orderly manner and shall be kept free from offensive odor.	V 736		

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V 736	Continued From page 51 This Rule is not met as evidenced by: Based on observation, record review and interview the facility was not maintained in a safe, clean and attractive manner. The findings are: Review on 12/2/21 of the facility's public record maintained by the Division of Health Service Regulation revealed a local Sanitation Inspection report dated 10/20/21 which included but not limited to the following: - 17 demerits identified - "fecal matter on toilet seat" - "toilet seat worn" - "shower curtain rod & rings rusty" - dining table finish "very worn" Observation and tour on 12/2/21 of the facility between 11:00am-12:00noon revealed the following: - male's bathroom vanity 2 of 4 light bulbs missing when flipped up, toilet seat had thick brown stains and residue on it - female bathroom vanity 1 light bulb not working bottom of tub stained blue and gray with a ring around it small indention the size of a fist noted in the wall - client #1's bedroom brown stains on clear plastic that covered mattress large circular stains throughout the carpet that ranged in sizes of a small saucer to a large plate dresser drawer mirror removed but sharp screw sticking out.	V 736	The QP will conduct inspections 2-3 times weekly to address cleanliness, safe and orderly conditions of the home and its grounds. The QP will complete a maintenance request form to correct any issues noted. The QP will follow-up weekly on all maintenance request orders to determine the status until corrected. All the issues noted from Sanitation Inspection are being addressed and such actions were taking place at the time of the survey as documentation was presented to the surveyors of the same. All issues noted from surveyor tour on 12/2/21 will be addressed. The QP continues to monitor in the home 2-3 times weekly to ensure continued compliance. The Director of Quality Management will review and track all Health and Sanitation Inspections conducted and will monitor in the home weekly to ensure continued compliance.	1/8/22 1/8/22 1/8/22 1/8/22 1/8/22

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V 736	Continued From page 52 2 small circular holes the size of cigarette butt noted in comforter - client #3's bedroom smeared red stain noted on the wall - dining area small oval shaped hard gray matter the size of a pill noted on arms, legs, bottom of chairs Interview on 12/2/21 staff #10 reported: - was not aware of a checklist for cleaning - one staff "was not a real cleaner", others cleaned - client #1 had toileting incidents often - client #1's mattress was replaced a couple of months ago and the plastic was left on the mattress. Interview on 12/3/21 staff #8 reported: - had a maintenance report system to report repair requests - repair requests were reported but not always completed - reported "leaking fridge & bulbs blown" - had a recent inspection and things got better - not aware of any required repairs at this time Interview on 12/3/21 the Qualified Professional (QP) #2 reported: - started 8/9/21 - considered this home "one of the best kept home in terms of cleanliness" - a maintenance report was completed monthly - staff submitted maintenance requests to him and he visited this group home twice a month - staff told him the indention in the female bathroom was made when former client (FC) #A7 from sister facility A punched the wall. He did not recall if the indention occurred prior to his 8/9/21 date of hire with the company. - was not aware of the stain on the	V 736		

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V 736	Continued From page 53 mattress/toilet seat/tub, holes in comforter, debris on dining chairs or any pending maintenance requests Interview on 12/2/21, Director of Quality Management (DQM) reported: - not aware of items observed during the tour except the stained carpet - repairs for the home had to be approved by Housing and Urban Development (HUD) - not sure the status of the carpet removal process or when it was submitted Review on 12/7/21 of a fax submitted by the DQM revealed: - "HUD repair not initiated, going the internal route to address repairs" - receipt dated 12/7/21 for new dining table attached Interview on 12/14/21 the DQM reported - with repairs, he noticed the condition during the 12/2/21 tour of the home - issues had been identified, addressed and resolved through management. - he monitored the home once every 2 months. Every other month or more often. - he had not reviewed the sanitation report conducted by the local health department. - agency put corrective actions in place. "It was brought to my attention." - agency had an outside company to clean the carpet. - agency completed a maintenance report. "I can't tell the specificity." - verified he saw something on the toilet. Later he found out the toilet was stained as result of sanitizing with Clorox and not fecal matter. - HUD contractor can take a while, so agency took the responsibility of addressing the	V 736		

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V 736	Continued From page 54 environmental concerns. - 12/2/21 was the "First time I noticed the hole in the wall. The [QP] would monitor the staff and oversight of assuring the cleaning of the home. Not spoke to him (QP) about Harmony. "I've not been at Harmony as frequently as some of the other homes." Interviews on 12/14/21 and 12/16/21, the Administrator reported: - had a cleaning crew 4-5 times for the carpet. - client had toileting accident the morning of the tour. He felt these issues were for that day, not ongoing - he had the table replaced prior to the end of the survey - "We have contracts for every facility. No staff have brought it to our attention about the home. They should report to management [DOO/QP #1 and DQM]." This deficiency is cross referenced into 10A NCAC 27G .0203 Competencies of Qualified Professionals and Associate Professionals (V109) for a Type A1 rule violation and must be corrected within 23 days.	V 736		
V 784	27G .0304(d)(12) Therapeutic and Habilitative Areas 10A NCAC 27G .0304 FACILITY DESIGN AND EQUIPMENT (d) Indoor space requirements: Facilities licensed prior to October 1, 1988 shall satisfy the minimum square footage requirements in effect at that time. Unless otherwise provided in these Rules, residential facilities licensed after October 1, 1988 shall meet the following indoor space requirements:	V 784		

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V 784	Continued From page 55 (12) The area in which therapeutic and habilitative activities are routinely conducted shall be separate from sleeping area(s). This Rule is not met as evidenced by: Based on interview and record review the facility failed to ensure areas in which therapeutic and habilitative activities are routinely conducted were separate from sleeping areas. The findings are: Review on 12/3/21 of FC #A7's record revealed: - unknown admission date to Sister Facility A and discharged from Sister Facility A on 11/19/21 - diagnoses: Pervasive Development Disorder, Unspecified, Anxiety Disorder Unspecified, Bipolar Disorder Unspecified, Moderate Intellectual Disabilities, Hearing Loss, Seizure Disorder, and Limited Communication Skills. Interview on 12/2/21 staff #9 reported: - fomer client (FC) #A7 was not a client of this facility. - FC #A7 slept over at the facility when there was a staffing issue at Sister Facility A. - FC #A7 slept over 3-4 times from September 2021-November 2021. - FC #A7 was observed sleeping on the sofa in the family room or the staff bedroom. Interview on 12/10/21 FS #11 reported: - worked at the facility since October 2020. - FC #A7 slept on the couch "on a regular basis." Interview on 12/6/21 FC #A7's guardian reported: - FC #A7 came to the facility with FC #A6 as there was no staff at Sister Facility A. - she was told that FC #A7 slept on the couch at the facility.	V 784	The facility will ensure coordination efforts with qualified professionals and management to ensure that sleeping quarters for the individuals are separate from areas utilized for habilitative or therapeutic activities. QP will maintain contact with all residential facilities daily to ensure that each home provide separate sleeping quarters for all individuals served. The Director of Operations will be notified immediately to help support the coordination of staff resources to ensure the home have separate sleeping quarters for any resident that is present in the home on an overnight basis. The Director of Operations, CEO and Director of Quality Management will discuss the occupancy status weekly to ensure continued compliance. The facility contends that at no time was a client forced to sleep on the couch and if it occurred it was the result of client choice and not the request of staff or management	1/822 1/8/22 1/8/22 1/8/22

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V 784	Continued From page 56 Interview on 12/10/21 FC #A6's Local Management Entity/Managed Care Organization Care Coordinator (LME/MCO/CC) reported: - she was aware that FC #A7 was staying overnight at the facility even though she was not the Care Coordinator for FC #A7. - she had been told that FC #A7 slept on the couch or a chair at the facility. Interview on 12/13/21 FC #A6 reported: - FC #A7 went to Harmony Home with her - FC #A7 slept on a couch Interview on 12/10/21 FC #A6's guardian reported: - a staff from Sister Facility A made her aware FC #A7 slept on the couch Interview on 12/10/21 the supervisor for (LME/MCO/CC) reported: - the guardian was upset FC #A7 had visits to Harmony Home - the guardian informed them FC #A7 slept on a couch during her visits to Harmony Home - on 10/19/21 a conference call was held with the Administrator, Director of Operations (DOO)/Qualified Professional (QP)#1 and the Director of Quality Management (DQM) - asked why she slept on a couch - was told FC #A7 had a history of destroying clients' bedrooms Interview on 12/14/21 the DOO/Qualified Professional (QP) #1 reported: - she was unaware that FC #A7 had slept on the couch at the facility Interview on 12/10/21 the DQM reported: - not aware FC #A7 had overnights at	V 784		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL043-075	A. BUILDING: _____ B. WING _____	R 12/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY HOME	808 NORTH MCKAY AVENUE DUNN, NC 28334

(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 784	Continued From page 57 Harmony Home or slept on a couch - "if she slept on a couch, was because she wanted to and that was her right" Interview on 12/10/21 the Administrator reported: - he paid Housing and Urban Development for a bed that was not occupied at Harmony Home - FC #A7 did not have to sleep on a couch - there was a client of the facility that took overnight passes home, and that client's bed was available, so there was no need for FC #A7 to sleep on the couch - Division of Health Service Regulation "information was 100% incorrect. We have some disgruntled employees." This deficiency is cross referenced into 10A NCAC 27G .0203 Competencies of Qualified Professionals and Associate Professionals (V109) for a Type A1 rule violation and must be corrected within 23 days.	V 784		

January 5, 2022

DHSR - Mental Health
JAN 5 – 2022
Lic. & Cert. Section

Ms. Renee Kowalski, Supervisor
Mental Health Licensure and Certification Section
N.C. Division of Health Service Regulation
2718 Mail Service Center
Raleigh, NC 27699-2718

Re: Annual, Complaint and Follow-up survey completed December 16, 2021
Harmony Home
808 North McKay Avenue
Dunn, NC 28334
MHL#043-075
Intake #NC00183246

Dear Ms. Kowalski:

See attached hard copy of the plan of correction (POC) for the Harmony Home's survey, completed 12/16/21. We hope that you will find the attached POC acceptable. If you have questions, feel free to contact myself or Vidya Persad, Director of Operations. Otherwise, we very much look forward to your follow-up visit.

Kindest regards,

James Harris, Director Quality Management

Victor & ASSOCIATES INC.
Provider of MH/IDD/SAS
Accredited by CQL The Council on Quality and Leadership

JAMES HARRIS, QP, MPA
Director, Quality Management

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