AME OF PF	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
AME OF PE		MHL085-026	B. WING		01/27/202	
446		STREET	ADDRESS, CITY, STATE	ZIP CODE		
NNACIE	HOMES #1		RCH ROAD			
	-11014125 #1	PINNAC	LE, NC 27043			
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLE DATE
V 000	INITIAL COMMENTS		V 000			
	Deficiencies were cite					
	category: 10A NCAC : Living for Adults with N					
	The survey sample co current clients.	nsisted of audits of 3				
V 105	27G .0201 (A) (1-7) G	overning Body Policies	V 105			
	10A NCAC 27G .0201 POLICIES (a) The governing bod	GOVERNING BODY y responsible for each develop and implement				
(written policies for the	following: gement authority for the and services;				
(criteria for discharg admission assessm who will perform the	e; nents, including:				
	B) time frames for con 5) client record manag A) persons authorized	npleting assessment. pement, including: to document;				
d (I	lefacement or use by υ D) assurance of record	Is against loss, tampering, unauthorized persons; d accessibility to				
(E	uthorized users at all t E) assurance of confid 6) screenings, which s A) an assessment of th	entiality of records.				
(E	roblem or need; 3) an assessment of w	hether or not the facility address the individual's				
(0	D) the disposition, inclusion of the disposition of	uding referrals and				

DHSR - Mental Health

If continuation sheet 1 of 8

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Lic. & Cert. Section

STATEMEN	of Health Service Regulit of Deficiencies of Correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (A. BUILDING:	CONSTRUCTION		E SURVEY IPLETED
		MHL085-026	B. WING		0.	1/27/2022
NAME OF F	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	E. ZIP CODE	1 0	112112022
PINNACL	E HOMES #1	PINNAC	ERCH ROAD CLE, NC 27043			
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
	recommendations; (7) quality assurance activities, including: (A) composition and a assurance and quality (B) written quality assimprovement plan; (C) methods for monitional quality and appropriatincluding delineation of services; (D) professional or cliral requirement that starprofessionals and provised by that area of service; (E) strategies for improfessionals and provised by the supervised by that area of service; (E) strategies for improfessionals and province of staff qualification professionals and province of all fatalities were being served in a residential programs at (H) adoption of standar and programmatic perfapplicable standards of purpose, "applicable standards of purpose, "applicable standards of purpose, "applicable standards of purpose, and the degree methods, and the degree assurance and the degree methods, and the degree assurance and programmatic perfapplicables, and the degree methods, and the degree assurance and programmatic perfapplicables, and the degree methods, and the degree assurance and programmatic perfapplicables, and the degree methods, and the degree assurance and programmatic perfapplicables, and the degree methods, and the degree assurance and programmatic perfapplicables and programmatic perfapplicables and programmatic perfapplicables, and the degree methods, and the degree assurance and programmatic perfapplicables.	and quality improvement activities of a quality improvement committee; urance and quality oring and evaluating the eness of client care, of client outcomes and nical supervision, including ff who are not qualified vide direct client services a qualified professional in oving client care; ifications and a grant orivileges: es of active clients who rea-operated or contracted the time of death; rds that assure operational ormance meeting f practice. For this andards of practice" etence established with	V 105			
rision of Health	Service Regulation					

Divi

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IW2H11

If continuation sheet 2 of 8

Division of Health Service R STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA				
		IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY
			A. BUILDING	:	CON	IPLETED
		MHL085-026	B. WING			
IAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY,				0.	1/27/2022	
				TATE, ZIP CODE		
PINNACLE	E HOMES #1		RCH ROAD			
(X4) ID	CI MANA DV CO		CLE, NC 27043			
PRÉFIX	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRE	CTION	(X5)
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP	DULD BE	COMPLE
				DEFICIENCY)	NOT THAT E	DAIL
V 105	Continued From page	e 2	V 105		***************************************	
and the same of th	This Rule is not met	as evidenced by:				
100	Based on record review	ews and interview, the				
1	facility failed to assure	e operational and			×	
	programmatic perform	nance meeting applicable			1/	
	standards of practice	by obtaining a Clinical	1	and de shower 14	111	
	Laboratory Improvem	ent Amendments (CLIA)		4 nnalle Homes to	leno	
		r monitoring. The findings		Soull all Hesident.	Š	
	аге:		****	Annalle Homes winsuk all residents an able to sat check blood susse Annalle Homes a have training to the saints to ens	ely	2-28
	Ravious on 1/20/2020	2 and 1/21/2022 of Client		114 Oble to out	2.7	0
	#2's record revealed:	and 1/21/2022 of Client	and the second	What Susad Susa	α .	
	- Admission date: 113	/2005		check good o	.311	
		nrenia, Paranoid type; Mild		Traballa Homes	Dill	
-	Intellectual Disability;	Diabetes Type II:		Annacce	OF	
	Hypertension; Hypoth	yroidism; Hyperlipidemia;		house training	0	
	Morbid obesity; and A	cid Reflux.		have to ens	ull	
-	 A physician's order for 	or daily and PRN (as		to suite -	HO	
1	needed) blood sugar to	esting, dated 7/29/2021.		they are usle- they are usle- check blood susce in accordance un	15	
	Review on 1/20/2022	of Client #2's medication		check blood suga	11.	
a	administration records	dated 11/1/2021 to	AND THE PARTY OF T	in accordance w	49	
1	1/20/2022 revealed:	55.54 1777252110	Name and the same	In acc.		
-	Blood sugar testing w	as completed daily.		276-0201.		
F	Review on 1/20/2022 o	of the facility's license		Pinnale Home Will obtain Cla Walter as right	.5	
0	locuments revealed:	of the facility's license		the of he political	14	
	No CLIA waiver had b	peen obtained	William Control	Mill Oblan CL	mil	
		January,	No.	WOUNT OUS HOW	160	
	nterview on 1/27/2022			Wall 246 17	01	
P pe gl	Professional/House Ma	nager revealed:	-	by NCPA 276.02	-1.	
	The facility did not have	ve a CLIA Waiver to				
	erform brood sugar m	onitoring with a		*		
	lucometer.			09		
-	racility staff did assist	Client #2 with testing her				
b	lood sugar every day.					
- fla	one nau never neard	of a CLIA Waiver or that	***************************************			
er i	e facility was required	to obtain one.	-			
			1		10	

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If continuation sheet 3 of 8

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY
			A. BUILDING:		CON	MPLETED
		MHL085-026	B. WING		0.	1/27/2022
IAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	E. ZIP CODE		ITETTEOZE
INNACLI	E HOMES #1		RCH ROAD			
		PINNAC	LE, NC 27043			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLE DATE
V 536	Continued From pag	e 3	V 536			
V 536	27E .0107 Client Rig Int.	hts - Training on Alt to Rest.	V 536			
() () () () () () () () () () () () () (to restrictive intervent (b) Prior to providing disabilities, staff inclu employees, students demonstrate compete completing training in other strategies for cr which the likelihood o or injury to a person w property damage is pr (c) Provider agencies based on state compete compliance and demo gathered. (d) The training shall be measurable testing (w pehavior) on those obj methods to determine course. (e) Formal refresher tr (by each service provid annually). (f) Content of the train provider wishes to emple deragraph (g) of this R (g) Staff shall demons collowing core areas:	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 eating an environment in fimminent danger of abuse with disabilities or others or revented. Is shall establish training etencies, monitor for internal enstrate they acted on data the competency-based, arming objectives, ritten and by observation of iectives and measurable passing or failing the raining must be completed for periodically (minimum ing that the service ploy must be approved by ISAS pursuant to				

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If continuation sheet 4 of 8

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DAT	E SURVEY
		I SEATH IOAHON NOWIDER.	A. BUILDING:			PLETED
		MHL085-026	B. WING			19710000
AME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS CITY STATE	7/0.0005	1 01	/27/2022
			ADDRESS, CITY, STATE RCH ROAD	E, ZIP CODE		
INNACL	E HOMES #1		LE, NC 27043			
(X4) ID PREFIX	SUMMARY S	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF	CORRECTION	(X5
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPL
V 536	Continued From page	ge 4	V 536	DEFICIENC	1)	-
	(2) recognizin	g and interpreting human				
	behavior;	g and mespreting namen				
	(3) recognizin	g the effect of internal and				
***************************************	external stressors th	at may affect people with				
	disabilities;					
	(4) strategies	for building positive				
***	(5) recognizing	ersons with disabilities;	-			
	organizational factor	g cultural, environmental and s that may affect people with				
	disabilities;	3 that may affect people with				
		g the importance of and				
	assisting in the perso	on's involvement in making				
	decisions about their	life;				
1		sessing individual risk for				
	escalating behavior;					
	(8) communica	ation strategies for defusing tentially dangerous behavior;				
	and	deridany dangerous behavior;				
		navioral supports (providing				
	means for people wit	h disabilities to choose				
	activities which direct	ly oppose or replace	·			
	behaviors which are	unsafe).	-			
	(h) Service providers	shall maintain				
	documentation of initi at least three years.	al and refresher training for				
		tion shall include:				
(ated in the training and the	-			
	outcomes (pass/fail);	and the				
(B) when and w	where they attended; and	-			
(2 re	C) instructor's	name;	The reason of th			
	2) The Division	n of MH/DD/SAS may	Vienness of the second			
	eview/request this do	ocumentation at any time.				
	 i) Instructor Qualifica Requirements: 	auons and Training				
		all demonstrate competence				
1 .	y scoring 100% on te	esting in a training program				
а	imed at preventing, r	educing and eliminating the				
n	eed for restrictive into	erventions.				
		Il demonstrate competence				

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If continuation sheet 5 of 8

STATEMEN	of Health Service Regu T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	CONSTRUCTION	(X3) DATE	SLIDVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:			COMP	
		MHL085-026	B. WING		01/2	27/2022
NAME OF P			ADDRESS, CITY, STATE	E, ZIP CODE		
PINNACLI	E HOMES #1	1169 PE	RCH ROAD			
	 		LE, NC 27043			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
	by scoring a passing of instructor training productives, measurable observation of behavior measurable methods failing the course. (4) The content service provider plans approved by the Divisito Subparagraph (i)(5) (5) Acceptable i shall include but are not approved by the Divisito Subparagraph (i)(5) (5) Acceptable i shall include but are not approved by the Divisito Subparagraph (i)(5) (6) Methods for performance; and (ii) documentation of methods for performance; and (iii) documentation of methods for performance; and (iii) documentation of methods for reducing and eliminating interventions at least or review by the coach. (7) Trainers shall aimed at preventing, remeed for restrictive interventions and preventing, remeed for restrictive interventions at least or restrictive interventions at least or review by the coach. (7) Trainers shall aimed at preventing, remeed for restrictive interventions at least or restrictive interventions.	grade on testing in an gram. shall be clude measurable learning e testing (written and by or) on those objectives and to determine passing or of the instructor training the to employ shall be on of MH/DD/SAS pursuant of this Rule. Instructor training programs of limited to presentation of: g the adult learner; teaching content of the evaluating trainee on procedures. I have coached experience gram aimed at preventing, ig the need for restrictive in time, with positive I teach a training program inducing and eliminating the riventions at least once I complete a refresher instructor e years. Itation shall include: ed in the training and the increase attended; and	V 536			
vision of Healt	h Service Regulation					

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If continuation sheet 6 of 8

TAG REGULATORY OR LSC IDENTIFYING INFORMATION) V 536 Continued From page 6 (2) The Division of MH/DD/SAS may request and review this documentation any time. (k) Qualifications of Coaches:		of Health Service Reg	ulation			FORM APPROV	/ED
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1169 PERCH ROAD PINNACLE HOMES #1 (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) V 536 Continued From page 6 (2) The Division of MH/DD/SAS may request and review this documentation any time. (k) Qualifications of Coaches:							
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1169 PERCH ROAD PINNACLE HOMES #1 PINNACLE, NC 27043 (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) V 536 Continued From page 6 (2) The Division of MH/DD/SAS may request and review this documentation any time. (k) Qualifications of Coaches:			MHL085-026	B. WING	Parada	01/27/2022	
(X4) ID PREFIX TAG V 536 Continued From page 6 (2) The Division of MH/DD/SAS may request and review this documentation any time. (k) Qualifications of Coaches:			1169 PE	RCH ROAD	ATE, ZIP CODE	1 0112112022	
(2) The Division of MH/DD/SAS may request and review this documentation any time. (k) Qualifications of Coaches:	PREFIX	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	BE COMPLET	E
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. (1) Documentation shall be the same preparation as for trainers. This Rule is not met as evidenced by: Based on record reviews and interviews, the		(2) The Divisio request and review the (k) Qualifications of (1) Coaches shad requirements as a transport of the course which is becompetence by competrain-the-trainer instruction (i) Documentation shad for trainers. This Rule is not met a Based on record review facility failed to ensure (#1, #2 & the Qualified Manager (QP/HM) recallernatives to restriction annually. The findings Reviews on 1/20/2022 employee record reversible the facility for alterninterventions) had exp. Recertification training completed on 1/24/2022 employee record reversible the facility for alterninterventions on 1/20/2022 employee record reversible the facility for alterninterventions on 1/20/2022 employee record reversible the facility for alterninterventions on 1/20/2022 employee record reversible the facility for alterninterventions on 1/20/2022 employee record reversible the facility for alterninterventions on 1/20/2022 employee record reversible the facility for alterninterventions on 1/20/2022 employee record reversible the facility for alterninterventions on 1/20/2022 employee record reversible the facility for alterninterventions on 1/20/2022 employee record reversible the facility for alterninterventions on 1/20/2022 employee record reversible the facility for alterninterventions on 1/20/2022 employee record reversible the facility for alterninterventions of the facility facility for alterninterventi	n of MH/DD/SAS may nis documentation any time. Coaches: nall meet all preparation iner. nall teach at least three times eing coached. nall demonstrate eletion of coaching or action. all be the same preparation as evidenced by: as and interviews, the a that 3 of 3 audited staff d Professional/House evived training on ve interventions at least are: a. & 1/26/2022 of Staff #1's aled: a training curriculum used natives to restrictive ired on "11/2021." ag on NCI+ had been 22. & 1/26/2022 of Staff #2's aled:		Pinnalle Homes will insur all staff teciene MCI training yearly as regulated in 10 A NCAC 27E.C	1242	

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If continuation sheet 7 of 8

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C	(X3) DAT	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:			PLETED
		MHL085-026	B. WING			1/07/000
AME OF F	PROVIDER OR SUPPLIER		INDERSON OUT A DESCRIPTION			/27/2022
			ADDRESS, CITY, STATE RCH ROAD	E, ZIP CODE		
INNACL	E HOMES #1		LE, NC 27043			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5 COMPL DAT
	- Training on NCI+ ha - Recertification training completed on 1/24/20 Reviews on 1/20/202 QP/HM's employee re - Hire date: 6/17/2010 - Training on NCI+ ha - Recertification training completed on 1/24/20 Interview on 1/21/202 - She did not think that staff whose NCI+ training - The QP/HM had schoourse for the upcomit interview on 1/21/202 - She did not know when NCI+ training The QP/HM schedule interview on 1/25/202 - Recertification training scheduled before the location training scheduled before the locatifications had expiration to the control of the location of loca	and expired on "11/2021." ing on NCI+ had been 1022. 2 & 1/26/2022 of the ecord revealed: and expired on "11/2021." Ing on NCI+ had been 1022. 2 with Staff #1 revealed: at she was the only facility hing had lapsed. Beduled an NCI+ refresher ng Monday (1/24/2022). 2 with Staff #2 revealed: By there had been a lapse in 10 led staff trainings. 2 with the QP/HM revealed: By for NCI+ had been 10 lefore NCI+ training 10 lefore NCI+ training 11 lefore 11 lefore 11 lefore 11 lefore 12 lefore 12 lefore 12 lefore 13 lefore 13 lefore 14 lefore 14 lefore 15 lefore 15 lefore 16 lefore 16 lefore 17 lefore 17 lefore 18 lefore 18 lefore 18 lefore 18 lefore 19 lef	V 536	DEFICIENC	Y)	

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