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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL085-026	A. BUILDING: _____ B. WING _____	01/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINNACLE HOMES #1	1169 PERCH ROAD PINNACLE, NC 27043

(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 000	INITIAL COMMENTS An annual survey was completed on 1/27/2022. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600A Supervised Living for Adults with Mental Illness. The survey sample consisted of audits of 3 current clients.	V 000		
V 105	27G .0201 (A) (1-7) Governing Body Policies 10A NCAC 27G .0201 GOVERNING BODY POLICIES (a) The governing body responsible for each facility or service shall develop and implement written policies for the following: (1) delegation of management authority for the operation of the facility and services; (2) criteria for admission; (3) criteria for discharge; (4) admission assessments, including: (A) who will perform the assessment; and (B) time frames for completing assessment. (5) client record management, including: (A) persons authorized to document; (B) transporting records; (C) safeguard of records against loss, tampering, defacement or use by unauthorized persons; (D) assurance of record accessibility to authorized users at all times; and (E) assurance of confidentiality of records. (6) screenings, which shall include: (A) an assessment of the individual's presenting problem or need; (B) an assessment of whether or not the facility can provide services to address the individual's needs; and (C) the disposition, including referrals and	V 105		

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Heather Shortcliff — House manager/AP — 2-18-22

STATE FORM 6899 IW2H11 If continuation sheet 1 of 8

DHSR - Mental Health
FEB 18 2022
Lic. & Cert. Section

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V 105	Continued From page 1 recommendations; (7) quality assurance and quality improvement activities, including: (A) composition and activities of a quality assurance and quality improvement committee; (B) written quality assurance and quality improvement plan; (C) methods for monitoring and evaluating the quality and appropriateness of client care, including delineation of client outcomes and utilization of services; (D) professional or clinical supervision, including a requirement that staff who are not qualified professionals and provide direct client services shall be supervised by a qualified professional in that area of service; (E) strategies for improving client care; (F) review of staff qualifications and a determination made to grant treatment/habilitation privileges: (G) review of all fatalities of active clients who were being served in area-operated or contracted residential programs at the time of death; (H) adoption of standards that assure operational and programmatic performance meeting applicable standards of practice. For this purpose, "applicable standards of practice" means a level of competence established with reference to the prevailing and accepted methods, and the degree of knowledge, skill and care exercised by other practitioners in the field;	V 105		

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V 105	Continued From page 2 This Rule is not met as evidenced by: Based on record reviews and interview, the facility failed to assure operational and programmatic performance meeting applicable standards of practice by obtaining a Clinical Laboratory Improvement Amendments (CLIA) waiver for blood sugar monitoring. The findings are: Reviews on 1/20/2022 and 1/21/2022 of Client #2's record revealed: - Admission date: 113/2005 - Diagnoses: Schizophrenia, Paranoid type; Mild Intellectual Disability; Diabetes, Type II; Hypertension; Hypothyroidism; Hyperlipidemia; Morbid obesity; and Acid Reflux. - A physician's order for daily and PRN (as needed) blood sugar testing, dated 7/29/2021. Review on 1/20/2022 of Client #2's medication administration records dated 11/1/2021 to 1/20/2022 revealed: - Blood sugar testing was completed daily. Review on 1/20/2022 of the facility's license documents revealed: - No CLIA waiver had been obtained. Interview on 1/27/2022 with the Qualified Professional/House Manager revealed: - The facility did not have a CLIA Waiver to perform brood sugar monitoring with a glucometer. - Facility staff did assist Client #2 with testing her blood sugar every day. - She had never heard of a CLIA Waiver or that the facility was required to obtain one.	V 105	Pinnacle Homes will insure all residents are able to safely check blood sugar. Pinnacle Homes will have training for residents to ensure they are able to check blood sugar in accordance with 27G 0201. Pinnacle Homes will obtain CLIA waiver as required by NCDA 27G.0201.	2-28-22

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V 536	Continued From page 3	V 536		
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 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;	V 536		

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V 536	Continued From page 4 (2) recognizing and interpreting human behavior; (3) recognizing the effect of internal and external stressors that may affect people with disabilities; (4) strategies for building positive relationships with persons with disabilities; (5) recognizing cultural, environmental and organizational factors that may affect people with disabilities; (6) recognizing the importance of and assisting in the person's involvement in making decisions about their life; (7) skills in assessing individual risk for escalating behavior; (8) communication strategies for defusing and de-escalating potentially dangerous behavior; and (9) positive behavioral supports (providing means for people with disabilities to choose activities which directly oppose or replace behaviors which are unsafe). (h) Service providers shall maintain documentation of initial and refresher training for 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	V 536		

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V 536	Continued From page 5 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. (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.	V 536		

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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: (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: Based on record reviews and interviews, the facility failed to ensure that 3 of 3 audited staff (#1, #2 & the Qualified Professional/House Manager (QP/HM) received training on alternatives to restrictive interventions at least annually. The findings are: Reviews on 1/20/2022 & 1/26/2022 of Staff #1's employee record revealed: - Hire date: 3/10/2015 - Training on NCI+ (the training curriculum used by the facility for alternatives to restrictive interventions) had expired on "11/2021." - Recertification training on NCI+ had been completed on 1/24/2022. Review on 1/20/2022 & 1/26/2022 of Staff #2's employee record revealed: - Hire date: 12/28/2010	V 536	Pinnacle Homes will insure all staff receive NCI training yearly as required in 10A NCAC 27E.017 Pinnacle staff completed training NCI + 1-24-22	1-24-22

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V 536	Continued From page 7 - Training on NCI+ had expired on "11/2021." - Recertification training on NCI+ had been completed on 1/24/2022. Reviews on 1/20/2022 & 1/26/2022 of the QP/HM's employee record revealed: - Hire date: 6/17/2010 - Training on NCI+ had expired on "11/2021." - Recertification training on NCI+ had been completed on 1/24/2022. Interview on 1/21/2022 with Staff #1 revealed: - She did not think that she was the only facility staff whose NCI+ training had lapsed. - The QP/HM had scheduled an NCI+ refresher course for the upcoming Monday (1/24/2022). Interview on 1/21/2022 with Staff #2 revealed: - She did not know why there had been a lapse in her NCI+ training. - The QP/HM scheduled staff trainings. Interview on 1/25/2022 with the QP/HM revealed: - Recertification training for NCI+ had been scheduled before the before NCI+ training certifications had expired for all staff. - The recertification trainings had to be canceled due to Covid-19 pandemic exposures, the NCI+ Trainer having been on vacation, and facility staff having taken vacation days. - She tried to schedule trainings for all facility staff at the same time in order to simplify tracking when recertification was due. - Usually, the facility did not have any problems with recertification trainings being completed on time.	V 536		