Division	of Health Service Regu	lation			FORIV	APPROVEL
	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE S			
		MHL041-903	B. WING		R 06/08/2022	
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, S	TATE ZIP CODE		
T			RITLEY COURT	THE, ZIF CODE		
THEOMB	RELLA GROUP		SBORO, NC 27	406		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES				
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETE DATE
V 000	INITIAL COMMENTS		V 000			
	completed on 6/8/202	and follow up survey was 2. The complaints were #NC189488 & NC189489).		RECEIVED		
	This facility is licensed	d for the following service		JUL 11 2022		
	Living for Adults with [27G .5600C Supervised Developmental Disabilities.		DHSR-MH Licensure Sect		
	This facility is licensed 1. The survey sample current client and 1 fo	for 4 and has a census of consisted of audits of 1 rmer client.				
V 291	27G .5603 Supervised	d Living - Operations	V 291	27G .5603 Supervised Living - Operation	ıs	
	10A NCAC 27G .5603 (a) Capacity. A facilit six clients when the cl developmental disabil on June 15, 2001, and than six clients at that provide services at no licensed capacity. (b) Service Coordinat maintained between the qualified professionals treatment/habilitation of (c) Participation of the Responsible Person. In provided the opportunity relationship with her or means as visits to the the facility. Reports shannually to the parent elegally responsible per Reports may be in writted conference and shall for progress toward meetic	OPERATIONS y shall serve no more than lents have mental illness or lities. Any facility licensed providing services to more time, may continue to more than the facility's lon. Coordination shall be le facility operator and the who are responsible for or case management. Family or Legally Each client shall be ty to maintain an ongoing his family through such facility and visits outside all be submitted at least of a minor resident, or the son of an adult resident. Ing or take the form of a locus on the client's		Qualified professionals will be retrained on the discharge method/state guidelin with coordination of care when membe admitted to another treatment facility vawaiting permanent placement. Agency provide the guardian/parent with a list of facilities that will meet their needs and continue to be a support system until the member has a successful transition to a placement chosen by the guardian/pare Training will occur within the next 30 da later than August 07, 2022 Administrative Staff will provide training monitor discharge follow-up documental ensure compliance with each discharge.	l/trained es along rs are while y will of other new nt. ys, no	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

PRINTED: 06/14/2022 FORM APPROVED Division of Health Service Regulation (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: R B. WING MHL041-903 06/08/2022 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 4308 BRITLEY COURT THE UMBRELLA GROUP GREENSBORO, NC 27406 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) V 291 V 291 Continued From page 1 activity opportunities based on her/his choices, needs and the treatment/habilitation plan. Activities shall be designed to foster community inclusion. Choices may be limited when the court or legal system is involved or when health or safety issues become a primary concern. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to coordinate care with the qualified professionals responsible for treatment/habilitation or case management affecting 1 of 1 former client s (FC #2). The

findings are:

Reviews on 6/2/2022 and 6/7/2022 of former client (FC) #2's record revealed:

- Admission date: 5/9/2022
- Discharge date: 6/1/2022
- Diagnoses: Anxiety Disorder, unspecified; Mild Intellectual Disabilities; Autistic Disorder; and Seizure Disorder
- Documentation of a history of school suspensions for inappropriately touching others, hitting others, throwing objects, walking away, activity refusal, property destruction, and physically assaulting his father and sister.
- Involuntary commitment to a local hospital emergency room on 5/28/2022 due to aggression.
- A discharge summary dated 6/1/2022 that noted discharge due to "unsafe and unmanageable behaviors."
- No documentation of coordination of care or assisting with the procurement of alternative residential treatment while he was at the hospital emergency room.

STATEMEN	n of Health Service Regul ENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE (CONSTRUCTION	T	
AND PLAN	N OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	ONSTRUCTION	(X3) DATE : COMPI	SURVEY PLETED
		MHL041-903	B. WING		1	R / 08/2022
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THELIME	BRELLA GROUP		RITLEY COURT	., ZIP CODE		
111111111111111111111111111111111111111	3KELLA GROUP		ISBORO, NC 27406	À		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECTIO		T
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V 291			V 291			-
	emergency departmer - Admission to hospita 5/28/2022 due to "agg	al emergency department on gressive behavior"				
	Guardian revealed: - On 5/28/2022, he red Executive Director (ED FC #2 had been taken emergency room due t - Before FC #2 treatme week about FC #2's tre sent him an email that longer going to accept Management Entity/Ma (LME/MCO) that FC #2 managed through The hospital had calle needed to be picked up	D) who informed him that in to the local hospital to a "breakdown." sent team had a meeting this reatment needs, the ED to noted the facility was not referrals from the Local lanaged Care Organization 12's Care Coordination was led and told him that FC #2				
	room Almost immediately a him that FC #2 needed sent him an email inforr against a facility staff hat facility could not take Frought FC #2 could not safely due to the severity of hite FC #2 was still at the laroom The facility had aband hospital emergency deposing blamed for it.	after the hospital staff told d to be picked up, the ED rming him that an allegation had been made and the FC #2 back. Ily return to his own home his behaviors. Ilocal hospital emergency doned FC #2 at the local epartment, but he was				
	Interview on 6/8/2022 w Social Worker (HSW) re - FC #2 had been in the TCU (trauma care unit)	revealed: e hospital emergency room				

- The facility discharged FC #2 as of the date he

was taken to the emergency room.

Division of	Health Service Regu				T(V2) DATE	CLIDVEV
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE Co	(X3) DATE	PLETED		
AND PLAN O	FCORRECTION	IDENTIFICATION NOWIBER.	A. BUILDING:			
1						R
		MHL041-903	B. WING		06	/08/2022
NAME OF DE	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE		
NAIVIE OF PR	ROVIDER ON SOLT ELER		RITLEY COURT			
THE UMB	RELLA GROUP	GREEN	SBORO, NC 27406			
	SLIMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRE	ECTION	(X5)
(X4) ID PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP		COMPLETE DATE
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	KOLKIATE	
V 291	Continued From pa	ge 3	V 291			
	- The ED was her c	ontact at the facility				
		she had spoken to anyone				
	from the facility was					
	- She had tried to a	rrange for FC #2 to return to				
		one from the facility had				
	returned her calls.					
	- The ED had delay	ed talking to her until she (the				
	ED) had FC #2's di	scharge paperwork finished.				
	- Her concern with	the facility was "Just the fact of				
	how they dropped	him (FC #2) off"				
		10000 1 0/0/0000 Hit the ED				
	100001	/2022 to 6/8/2022 with the ED				
	revealed:					
	- FC #2 had been i	nvoluntarily committed to a				
	aggressive behavi	rgency room following				
	She had notified	FC #2's Guardian of the				
	admission the sam					
	- She had sent out	emails to FC #2's treatment				
	team to let them ki	now what had happened.				
	- She had been in	constant contact with the				
	hospital.					
	- On 5/31/2022, sh	ne sent out email notices to her				
		IE/MCO's she contracted with				
	to inform them that	it she was terminating her				
	contract agreeme	nts with them.				
	- She received an	emergency treatment team				
		or FC #2 the next day				
	(6/1/2022).	- Ct-##1 had physically abused				
		at Staff #1 had physically abused				
	FC #2 was reported	ed at that meeting. n made several demands				
	because of the all					
	The Guardian h	ad reported that he was not				
	comfortable with	FC #2 returning to the facility				
	and had been in o	contact with two other potential				
	residential placer	nents for FC #2.				
	- Since then, she	had not heard from FC #2's				
	Care Coordinator	or Guardian about assisting				

with locating alternative placement for him

PRINTED: 06/14/2022 FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A BUILDING COMPLETED R MHL041-903 B. WING 06/08/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4308 BRITLEY COURT THE UMBRELLA GROUP GREENSBORO, NC 27406 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) V 291 Continued From page 4 V 291 - She had not received any calls from the hospital since she gave hospital staff FC #2's Care Coordinator contact information on 6/1/2022. - She had been willing to work with FC #2, but after FC #2's Guardian made additional demands and the allegation against Staff #1 was made, she did not think it sounded beneficial for FC #2 to return to the facility. V 318 130 .0102 HCPR - 24 Hour Reporting V 318 130 .0102 HCPR - 24 Hour Reporting 10A NCAC 13O .0102 INVESTIGATING AND Qualified Professionals and all service providers REPORTING HEALTH CARE PERSONNEL will be retrained on Incident Reporting to The reporting by health care facilities to the Department of all allegations against health care include all Internal and External Reporting of personnel as defined in G.S. 131E-256 (a)(1), Level 1, 2, 3, Staff allegation/member allegation including injuries of unknown source, shall be reporting, 24 Hours Working Report, 5 Day done within 24 hours of the health care facility Working Report, IRIS reports, Reporting to the becoming aware of the allegation. The results of Department of Social Services. All training will the health care facility's investigation shall be be done according to state guidelines G.S.131Esubmitted to the Department in accordance with 256(g). G.S. 131E-256(g). Qualified professionals will be trained/retrained on documenting all and any verbal and nonverbal incidents and allegations and any reported incidents documenting reported information given concerning any and all incidents. Qualified professionals will be

Division of Health Service Regulation

This Rule is not met as evidenced by:

staff (#1). The findings are:

Based on record reviews and interviews, the facility failed to report allegations against health

care personnel within 24 hours of becoming

aware of the allegation affecting 1 of 3 audited

Review on 6/2/2022 of Staff #1's employee record

1CZJ11

trained in internal investigating allegations and submitting documentation according to state

Training will occur within the next 45 days, no

Administrative Staff will provide training and assure that reporting is being completed timely.

guidelines G.S.131E-256(g).

later than August 07, 2022.

STATEMENT	Health Service Regul OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
AND PLAN O	IF CORRECTION	ISENTI ISENTI	A. BUILDING:		
		MHL041-903	B. WING		R 06/08/2022
NAME OF PE	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE	
THE OF T	10110211011011	4308 BRI	TLEY COURT		
THE UMBI	RELLA GROUP	GREENS	BORO, NC 27	7406	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORR	
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24.040	0	E	V 318	Administrative Staff will monitor	
V 318	Continued From pag	je 5	V 310	all incidents to ensure document	ation is
100	revealed:			completed and time-stamped or	a daily basis.
	- Hire date: 1/30/201	5 as a paraprofessional			
	- Documentation of	clinical supervision notes			
	completed by the fo	rmer Qualified Professional			
	(FQP) on 3/1/2022 a	and 3/21/2022 with no issues			
	related to job perfor	mance identified.			
	Reviews on 6/2/202	22 and 6/7/2022 of former			
	client (FC) #2's record revealed: - Admission date: 5/9/2022 - Discharge date: 6/1/2022 - No Disorder - A discharge summary dated 6/1/2022 that noted				
	discharge due to "u	nsafe and unmanageable			
	behaviors."				
		umentation that an allegation			
		2022 that Staff #1 physically			
	and verbally abuse	d FC #2.			
	Review on 6/1/2022	2 of the Incident Response			
	Improvement Syste	em (IRIS) revealed:			
		ts were present for the facility			
	from 1/1/2022 to 6/				
		ded a section that permitted			
		ne initial notification of			
	allegations against	health care personnel to the			
	Health Care Perso	nnel Registry (HCPR).			
	- There was no do	cumentation that an allegation			
	of physical and verbal abuse of FC #2 had been made on 5/21/2022 against Staff #1.				
	Interview on 6/1/20	222 with the Local Management			
	Entity/Managed Co	are Organization (LME/MCO)			
		or reviewing IRIS reports for the			
	facility revealed:	f - th - 5/24/2022 allogation of			
	- The IRIS report	for the 5/21/2022 allegation of			
	abuse against Sta	aff #1 was originally submitted			
	by the Executive I	Director (ED) on 5/25/2022 but			
	was not actually r	eceived by the LME/MCO until			

5/31/2022 due to errors with the county selection

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY MPLETED
		MHL041-903	A. BOILDING: R B. WING 06/08/2022			
NAME OF F	ROVIDER OR SUPPLIER		ADDRESS, CITY, STA	TE ZIR CODE	0	6/08/2022
THELIME	PELLA CROUD		RITLEY COURT	TE, ZII GODE		
THEONE	RELLA GROUP	GREENS	SBORO, NC 2740	96		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
	on the form. - While the incident re the Surveyor, it was v staff. Review on 6/1/2022 or facility's IRIS reports r - On 5/21/2022, FC #2 #1 had choked him. - The incident report w Staff #1 was not submode with the survey on 6/1/2022 of Report form revealed: - An allegation of reside completed and signed to a management of the incident date and completed and signed to the incident date and linterview on 6/2/2022 of the only worked one-one-one-one-one-one-one-one-one-one-	eport was not viewable by iewable by the LME/MCO If printed copies of the evealed: It told his Guardian that Staff If the allegation against itted until 5/25/2022. If an HCPR 24-Hour Initial ent abuse by Staff #1 was by the ED on 5/24/2022. If time were "unknown." with Staff #1 revealed: on-one with Client #1. In FC #2. e-on-one staff working with If physical and verbal list him on 5/21/2022, the et with him to investigate and 6/8/2022 with the ssional (FQP) revealed: ed on the morning of eported to his Guardian ed him by the neck and occurred on 5/12/2022 and the submitted until	V 318			
	milerview from 6/1/2022	2 to 6/8/2022 with the ED				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING:	COMPLETED R		
		MHL041-903	B. WING		06/08/2022
	ROVIDER OR SUPPLIER	4308 BR	DDRESS, CITY, STA		
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
V 318	revealed: - On 5/21/2022, FC and choked him The FQP had learn 5/21/2022 The FQP was suppallegation against St within 24 hours The FQP had aske entering the IRIS report was term The FQP had not processary to make and the report was not until 5/26/2022 after.	#2 alleged that Staff #1 had ned of the allegation on posed to have entered the taff #1 into an IRIS report and for her assistance with port on 5/24/2022. provided her with the code corrections on the IRIS report. actually entered into IRIS as she was able to get a code the LME/MCO responsible	V 318		
V 536	Int. 10A NCAC 27E .01 ALTERNATIVES TO INTERVENTIONS (a) Facilities shall in practices that emph to restrictive interved (b) Prior to providing disabilities, staff indemployees, student demonstrate completing training other strategies for which the likelihood or injury to a person property damage is (c) Provider agence based on state completing training other strategies for which the likelihood or injury to a person property damage is (c) Provider agence based on state completing training other strategies for which the likelihood or injury to a person property damage is (c) Provider agence based on state completing training	mplement policies and pasize the use of alternatives entions. In gervices to people with eluding service providers, as or volunteers, shall betence by successfully in communication skills and creating an environment in a of imminent danger of abuse in with disabilities or others or	V 536	27E .0107 Client Rights - Training or to Rest. Int. All incoming staff / new staff will be training on alternatives to restrictive interventions (NCI+) before the hire/All existing staff will be trained on alt to restrictive interventions (NCI+) widays of the expiration of current trainals as a part of onboarding, Administrat will complete the final review and significant the audited personal files prior to hir dates to ensure that the staff is in conditional training and establish a future sched expiring training. Staff will review not expiring training via email.	start date. start date. sternatives thin 30 ning. sive staff gn-off on se/ start mpliance. start staff ule for all

STATEMEN	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIE	PLE CONSTRUCTION	(X3) DATE S	211DVEV
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPL	
			A. BOILDING	J		
					1	R
		MHL041-903	B. WING		06/0	08/2022
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE 7/D CODE		1-11-
				TATE, ZIP CODE		
THEUME	RELLA GROUP		TLEY COURT			
		GREENS	BORO, NC 27	406		
(X4) ID		ATEMENT OF DEFICIENCIES	D	PROVIDER'S PLAN OF CORRECTION		(X5)
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			TAG	CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	JATE	DATE
1/ 500	<u> </u>					
V 536	Continued From page	8	V 536	Administrative staff will track and mor	litor the	
	gathered.			training schedule monthly to ensure		
		be competency-based,		compliance.		
	include measurable le					
		ritten and by observation of		Training will occur within the next 45 of	lays, no	
	behavior) on those of	ejectives and measurable		later than August 07, 2022.		
		passing or failing the				
	course.	passing of faming the		Administrative Staff will provide training	ng and	
	- 100 M 100 M 100 M	raining must be completed		assure that reporting is completed wit		
		der periodically (minimum		allotted time for all required reporting		
	annually).	der periodically (millimati		agencies.		
	(f) Content of the train	ning that the service		agencies.		
		ploy must be approved by				
	the Division of MH/DD					
	Paragraph (g) of this F			*		
		strate competence in the				
	following core areas:	strate competence in the				
	1 T	and understanding of the				
	people being served;	and anderstanding of the				
		and interpreting human				
	behavior;	and interpreting numan				
		the effect of internal and				
		may affect people with				
	disabilities:	may alloot people with		_		
	(4) strategies fo	r building positive				
	relationships with pers					
		cultural, environmental and				
		that may affect people with				
	disabilities:	, and poop to that				
	(6) recognizing t	the importance of and				
		's involvement in making				
	decisions about their li					
		ssing individual risk for				İ
	escalating behavior;					ĺ
		on strategies for defusing				
		entially dangerous behavior;				
	and	y sanger add believior,				
		avioral supports (providing				- 1
	means for people with					
	activities which directly					- 1
	uncon uncony	oppose of replace				- 1

PRINTED: 06/14/2022 FORM APPROVED Division of Health Service Regulation (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION A. BUILDING: 06/08/2022 B. WING MHL041-903 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 4308 BRITLEY COURT THE UMBRELLA GROUP GREENSBORO, NC 27406 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID COMPLETE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) V 536 Continued From page 9 V 536 behaviors which are unsafe). (h) Service providers shall maintain documentation of initial and refresher training for at least three years. Documentation shall include: (1)who participated in the training and the (A) outcomes (pass/fail); when and where they attended; and (B) (C) instructor's name; The Division of MH/DD/SAS may (2)review/request this documentation at any time. (i) Instructor Qualifications and Training Requirements: Trainers shall demonstrate competence (1) by scoring 100% on testing in a training program aimed at preventing, reducing and eliminating the need for restrictive interventions. Trainers shall demonstrate competence (2)by scoring a passing grade on testing in an instructor training program. 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. The content of the instructor training the (4) service provider plans to employ shall be approved by the Division of MH/DD/SAS pursuant to Subparagraph (i)(5) of this Rule. Acceptable instructor training programs (5)shall include but are not limited to presentation of:

(A)

(B) course;

(C)

(D)

(6)

performance; and

understanding the adult learner;

methods for evaluating trainee

documentation procedures.

methods for teaching content of the

Trainers shall have coached experience

PRINTED: 06/14/2022 FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: COMPLETED R B. WING MHL041-903 06/08/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4308 BRITLEY COURT THE UMBRELLA GROUP GREENSBORO, NC 27406 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION **PREFIX** (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) COMPLETE CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) V 536 Continued From page 10 V 536 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. 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. Documentation shall include: (1) (A) who participated in the training and the outcomes (pass/fail); when and where attended; and (B) (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. Coaches shall teach at least three times the course which is being coached. Coaches shall demonstrate competence by completion of coaching or train-the-trainer instruction. (I) Documentation shall be the same preparation as for trainers.

Division of Health Service Regulation

This Rule is not met as evidenced by:

Based on record review and interview, the facility

Division of Health Service Regulation (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: 06/08/2022 B WING MHL041-903 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 4308 BRITLEY COURT THE UMBRELLA GROUP GREENSBORO, NC 27406 PROVIDER'S PLAN OF CORRECTION (X5)SUMMARY STATEMENT OF DEFICIENCIES COMPLETE (EACH CORRECTIVE ACTION SHOULD BE (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) V 536 Continued From page 11 V 536 failed to ensure staff completed training on alternatives to restrictive interventions prior to providing services affecting 1 of 3 audited staff (Staff #2); and failed to ensure formal refresher training was completed at least annually affecting 2 of 3 audited staff (#1 & the Executive Director (ED)) The findings are: Review on 6/2/2022 of Staff #1's employee record revealed: - Hire date: 1/30/2015 - Documentation that training in NCI+ (the curriculum used by the facility for training on alternatives to restrictive interventions) expired on 2/23/2022. - Formal refresher training was not completed until 5/4/2022. Review on 6/2/2022 of Staff #2 employee record revealed: - Hire date: 4/29/2022 - Documentation that training in NCI+ was not completed until 5/12/2022. Review on 6/2/2022 of the ED's employee record - Hire date: 12/1/2008 - Only her most recent NCI+ training certificate Formal refresher training in NCI+ was completed on 5/12/2022. Interview on 6/8/2022 with the ED revealed: - The facility usually had an NCI+ training for all staff in March of every year. - She had to reschedule the training due to Covid-19 issues and the usual trainer being unable to facilitate the training when the facility

Division of Health Service Regulation

needed it.

- Staff #1 had been sick for a period of time, so

STATE FORM

STATEMEN	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(V2) MI II TI	DI F CONCEDITOR OF	
	OF CORRECTION	IDENTIFICATION NUMBER:	1	PLE CONSTRUCTION	(X3) DATE SURVEY
			A. BUILDIN	G:	COMPLETED
		MHL041-903	B. WING _		R 06/08/2022
NAME OF P	PROVIDER OR SUPPLIER	STREET	ADDRESS OF S	TATE TO CODE	00/00/2022
			ADDRESS, CITY, S		
THE UMB	RELLA GROUP		RITLEY COURT		
			ISBORO, NC 2	7406	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD & CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETE
V 536	Continued From page	12	V 536		
	he missed his original training Staff #2 was new, so training in NCI+ before clients She had been sick difamily who had been strainings during those - Prior to the refresher 2022; her last training 2020.	scheduled refresher he did not have his initial he he started working with uring the past year, had sick, and had missed times. training she took in April had been some time in	V 536		
	10A NCAC 27E .0108 SECLUSION, PHYSIC ISOLATION TIME-OU (a) Seclusion, physica time-out may be emplo been trained and have competence in the prop to these procedures. F staff authorized to emp procedures are retraine competence at least an (b) Prior to providing di disabilities whose treate includes restrictive intel service providers, empl volunteers shall comple seclusion, physical rest and shall not use these training is completed an demonstrated. (c) A pre-requisite for ta demonstrating compete	AL RESTRAINT AND T Il restraint and isolation yed only by staff who have demonstrated per use of and alternatives facilities shall ensure that loy and terminate these ed and have demonstrated anually. The care to people with ment/habilitation plan reventions, staff including oyees, students or the training in the use of traint and isolation time-out interventions until the and competence is the competence is the competence of the competence		All incoming staff / new staff will be trai Seclusion, Physical Restraint, and Isolatinime-out (NCI+) before the hire/start day existing staff will be trained on Seclusion Physical Restraint, and Isolation Time-out (NCI+) within 30 days of the expiration of current training. As a part of onboarding, Administrative swill complete the final review and signothe audited personal files prior to hire/s dates to ensure that the staff is in complex to ensure that the staff is in complex training and establish a future schedule fexpiring training. Staff will review notific expiring training via email. Training will occur immediately and no lathan August 07, 2022.	ned on on te. All n, at on staff ff on tart iance. at staff or all ations

PRINTED: 06/14/2022 FORM APPROVED Division of Health Service Regulation (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: R 06/08/2022 B. WING MHL041-903 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 4308 BRITLEY COURT THE UMBRELLA GROUP GREENSBORO, NC 27406 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) Administrative Staff will provide training and V 537 Continued From page 13 V 537 ensure that all staff remain in compliances with (d) The training shall be competency-based, training requirement. 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: refresher information on alternatives to (1)the use of restrictive interventions; guidelines on when to intervene (understanding imminent danger to self and others); emphasis on safety and respect for the (3)rights and dignity of all persons involved (using concepts of least restrictive interventions and incremental steps in an intervention); strategies for the safe implementation (4)of restrictive interventions; the use of emergency safety (5)interventions which include continuous assessment and monitoring of the physical and psychological well-being of the client and the safe use of restraint throughout the duration of the

(6)

(7)

(8)

restrictive intervention;

at least three years.

importance and purpose; and

(h) Service providers shall maintain

prohibited procedures;

debriefing strategies, including their

documentation methods/procedures.

documentation of initial and refresher training for

	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		MHL041-903	B. WING		R 06/08/2022
	PROVIDER OR SUPPLIER	4308 BF	ADDRESS, CITY, STAT RITLEY COURT SBORO, NC 2740		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETE
V 537	(1) Documental (A) who particip outcomes (pass/fail); (B) when and w (C) instructor's in (2) The Division review/request this do (i) Instructor Qualifical Requirements: (1) Trainers shat by scoring 100% on the aimed at preventing, reneed for restrictive interestrictive	tion shall include: ated in the training and the there they attended; and name. I of MH/DD/SAS may cumentation at any time. Ition and Training Ill demonstrate competence esting in a training program educing and eliminating the erventions. Ill demonstrate competence sting in a training program clusion, physical restraint Ill demonstrate competence rade on testing in an iram. Ishall be clude measurable learning the testing (written and by ir) on those objectives and o determine passing or of the instructor training the to employ shall be on of MH/DD/SAS pursuant of this Rule. Instructor training programs the initial content of the trainee performance; and	V 537		

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PRINTED: 06/14/2022 FORM APPROVED Division of Health Service Regulation (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED. AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: B. WING 06/08/2022 MHL041-903 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 4308 BRITLEY COURT THE UMBRELLA GROUP GREENSBORO, NC 27406 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) V 537 Continued From page 15 V 537 annually and demonstrate competence in the use of seclusion, physical restraint and isolation time-out, as specified in Paragraph (a) of this Rule. Trainers shall be currently trained in (8)CPR. Trainers shall have coached experience (9)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. Trainers shall complete a refresher (11)

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.

(I) 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.

(m) Documentation shall be the same preparation as for trainers.

PRINTED: 06/14/2022 FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: COMPLETED R MHL041-903 B. WING 06/08/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4308 BRITLEY COURT THE UMBRELLA GROUP GREENSBORO, NC 27406 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) V 537 Continued From page 16 V 537 This Rule is not met as evidenced by: Based on record reviews and interview, the facility failed to ensure staff completed training in seclusion, physical restraint and isolation time out prior to providing services affecting 1 of 3 audited staff (Staff #2); and failed to ensure formal refresher training in seclusion, physical restraint and isolation time out was completed at least annually affecting 2 of 3 audited staff (#1 & the Executive Director (ED)). The findings are: Review on 6/2/2022 of Staff #1's employee record revealed: - Hire date: 1/30/2015 - Documentation that training in NCI+ Restrictive (the curriculum used by the facility for training in seclusion, physical restraint and isolation time out) expired on 2/23/2022. - Formal refresher training was not completed until 5/4/2022. Review on 6/2/2022 of Staff #2 employee record revealed: - Hire date: 4/29/2022 - Documentation that training in NCI+ Restrictive

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revealed.

- Hire date: 12/1/2008

certificate was present.

was completed on 5/12/2022.

was not completed until 5/12/2022.

Review on 6/2/2022 of the ED's employee record

- Only her most recent NCI+ Restrictive training

- Formal refresher training in NCI+ Restrictive

Interview on 6/8/2022 with the ED revealed: - The facility usually had an NCI+ Restrictive training for all staff in March of every year. - She had to reschedule the training due to

FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING: ___ R B. WING _ 06/08/2022 MHL041-903 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 4308 BRITLEY COURT THE LIMBRELLA GROUP

(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 537	Continued From page 17 Covid-19 issues and the usual trainer being unable to facilitate the training when the facility needed it. - Staff #1 had been sick for a period of time, so he missed his original scheduled refresher training. - Staff #2 was new, so he did not have his initial training in NCI+ Restrictive before he started working with clients. - She had been sick during the past year, had family who had been sick, and had missed trainings during those times. - Prior to the refresher training she took in April 2022; her last training had been some time in 2020.	V 537		