STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL041-903	A. BUILDING: _____ B. WING _____	R 06/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE UMBRELLA GROUP	4308 BRITLEY COURT GREENSBORO, NC 27406

(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, complaint and follow up survey was completed on 6/8/2022. The complaints were substantiated (intake #NC189488 & NC189489). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities. This facility is licensed for 4 and has a census of 1. The survey sample consisted of audits of 1 current client and 1 former client.	V 000	RECEIVED JUL 11 2022 DHSR-MH Licensure Sect	
V 291	27G .5603 Supervised Living - Operations 10A NCAC 27G .5603 OPERATIONS (a) Capacity. A facility shall serve no more than six clients when the clients have mental illness or developmental disabilities. Any facility licensed on June 15, 2001, and providing services to more than six clients at that time, may continue to provide services at no more than the facility's licensed capacity. (b) Service Coordination. Coordination shall be maintained between the facility operator and the qualified professionals who are responsible for treatment/habilitation or case management. (c) Participation of the Family or Legally Responsible Person. Each client shall be provided the opportunity to maintain an ongoing relationship with her or his family through such means as visits to the facility and visits outside the facility. Reports shall be submitted at least annually to the parent of a minor resident, or the legally responsible person of an adult resident. Reports may be in writing or take the form of a conference and shall focus on the client's progress toward meeting individual goals. (d) Program Activities. Each client shall have	V 291	27G .5603 Supervised Living - Operations Qualified professionals will be retrained/trained on the discharge method/state guidelines along with coordination of care when members are admitted to another treatment facility while awaiting permanent placement. Agency will provide the guardian/parent with a list of other facilities that will meet their needs and continue to be a support system until the member has a successful transition to a new placement chosen by the guardian/parent. Training will occur within the next 30 days, no later than August 07, 2022 Administrative Staff will provide training and monitor discharge follow-up documentation to ensure compliance with each discharge.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL041-903	A. BUILDING: _____ B. WING _____	R 06/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE UMBRELLA GROUP	4308 BRITLEY COURT GREENSBORO, NC 27406

(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 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.	V 291		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL041-903	A. BUILDING: _____ B. WING _____	R 06/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE UMBRELLA GROUP	4308 BRITLEY COURT GREENSBORO, NC 27406

(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 291	Continued From page 2 Review on 6/7/2022 for FC #2's local hospital emergency department records revealed: - Admission to hospital emergency department on 5/28/2022 due to "aggressive behavior" Interviews from 6/3/2022 to 6/8/2022 with FC #2's Guardian revealed: - On 5/28/2022, he received a call from the Executive Director (ED) who informed him that FC #2 had been taken to the local hospital emergency room due to a "breakdown." - Before FC #2 treatment team had a meeting this week about FC #2's treatment needs, the ED sent him an email that noted the facility was no longer going to accept referrals from the Local Management Entity/Managed Care Organization (LME/MCO) that FC #2's Care Coordination was managed through. - The hospital had called and told him that FC #2 needed to be picked up from the emergency room. - Almost immediately after the hospital staff told him that FC #2 needed to be picked up, the ED sent him an email informing him that an allegation against a facility staff had been made and the facility could not take FC #2 back. - FC #2 could not safely return to his own home due to the severity of his behaviors. - FC #2 was still at the local hospital emergency room. - The facility had abandoned FC #2 at the local hospital emergency department, but he was being blamed for it. Interview on 6/8/2022 with the local Hospital Social Worker (HSW) revealed: - FC #2 had been in the hospital emergency room TCU (trauma care unit) since 5/28/2022. - The facility discharged FC #2 as of the date he was taken to the emergency room.	V 291		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL041-903	A. BUILDING: _____ B. WING _____	R 06/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE UMBRELLA GROUP	4308 BRITLEY COURT GREENSBORO, NC 27406

(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 291	Continued From page 3 - The ED was her contact at the facility. - The last date that she had spoken to anyone from the facility was 6/2/2022. - She had tried to arrange for FC #2 to return to the facility, but no one from the facility had returned her calls. - The ED had delayed talking to her until she (the ED) had FC #2's discharge paperwork finished. - Her concern with the facility was "Just the fact of how they dropped him (FC #2) off ..." Interviews from 6/1/2022 to 6/8/2022 with the ED revealed: - FC #2 had been involuntarily committed to a local hospital emergency room following aggressive behavior on 5/28/2022. - She had notified FC #2's Guardian of the admission the same day. - She had sent out emails to FC #2's treatment team to let them know what had happened. - She had been in constant contact with the hospital. - On 5/31/2022, she sent out email notices to her contacts at the LME/MCO's she contracted with to inform them that she was terminating her contract agreements with them. - She received an emergency treatment team meeting request for FC #2 the next day (6/1/2022). - An allegation that Staff #1 had physically abused FC #2 was reported at that meeting. - FC #2's Guardian made several demands because of the allegation. - The Guardian had reported that he was not comfortable with FC #2 returning to the facility and had been in contact with two other potential residential placements 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	V 291		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL041-903	A. BUILDING: _____ B. WING _____	R 06/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE UMBRELLA GROUP	4308 BRITLEY COURT GREENSBORO, NC 27406

(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 291	Continued From page 4 - 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 291		
V 318	13O .0102 HCPR - 24 Hour Reporting 10A NCAC 13O .0102 INVESTIGATING AND REPORTING HEALTH CARE PERSONNEL The reporting by health care facilities to the Department of all allegations against health care personnel as defined in G.S. 131E-256 (a)(1), including injuries of unknown source, shall be done within 24 hours of the health care facility becoming aware of the allegation. The results of the health care facility's investigation shall be submitted to the Department in accordance with G.S. 131E-256(g). This Rule is not met as evidenced by: 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 staff (#1). The findings are: Review on 6/2/2022 of Staff #1's employee record	V 318	13O .0102 HCPR - 24 Hour Reporting Qualified Professionals and all service providers will be retrained on Incident Reporting to include all Internal and External Reporting of Level 1, 2, 3, Staff allegation/member allegation reporting, 24 Hours Working Report, 5 Day Working Report, IRIS reports, Reporting to the Department of Social Services. All training will be done according to state guidelines 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 trained in internal investigating allegations and submitting documentation according to state guidelines G.S.131E-256(g). Training will occur within the next 45 days, no later than August 07, 2022. Administrative Staff will provide training and assure that reporting is being completed timely.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL041-903	A. BUILDING: _____ B. WING _____	R 06/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE UMBRELLA GROUP	4308 BRITLEY COURT GREENSBORO, NC 27406

(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 318	Continued From page 5 revealed: - Hire date:1/30/2015 as a paraprofessional - Documentation of clinical supervision notes completed by the former Qualified Professional (FQP) on 3/1/2022 and 3/21/2022 with no issues related to job performance identified. 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 - No Disorder - A discharge summary dated 6/1/2022 that noted discharge due to "unsafe and unmanageable behaviors." - There was no documentation that an allegation was made on 5/21/2022 that Staff #1 physically and verbally abused FC #2. Review on 6/1/2022 of the Incident Response Improvement System (IRIS) revealed: - No incident reports were present for the facility from 1/1/2022 to 6/1/2022. - IRIS reports included a section that permitted facilities to make the initial notification of allegations against health care personnel to the Health Care Personnel Registry (HCPR). - There was no documentation that an allegation of physical and verbal abuse of FC #2 had been made on 5/21/2022 against Staff #1. Interview on 6/1/2022 with the Local Management Entity/Managed Care Organization (LME/MCO) staff responsible for reviewing IRIS reports for the facility revealed: - The IRIS report for the 5/21/2022 allegation of abuse against Staff #1 was originally submitted by the Executive Director (ED) on 5/25/2022 but was not actually received by the LME/MCO until 5/31/2022 due to errors with the county selection	V 318	Administrative Staff will monitor and tracking of all incidents to ensure documentation is completed and time-stamped on a daily basis.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL041-903	A. BUILDING: _____ B. WING _____	R 06/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE UMBRELLA GROUP	4308 BRITLEY COURT GREENSBORO, NC 27406

(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 318	Continued From page 6	V 318		

on the form.
- While the incident report was not viewable by the Surveyor, it was viewable by the LME/MCO staff.

Review on 6/1/2022 of printed copies of the facility's IRIS reports revealed:
- On 5/21/2022, FC #2 told his Guardian that Staff #1 had choked him.
- The incident report with the allegation against Staff #1 was not submitted until 5/25/2022.

Review on 6/1/2022 of an HCPR 24-Hour Initial Report form revealed:
- An allegation of resident abuse by Staff #1 was completed and signed by the ED on 5/24/2022.
- The incident date and time were "unknown."

Interview on 6/2/2022 with Staff #1 revealed:
- He only worked one-on-one with Client #1.
- He never worked with FC #2.
- FC #2 always had one-on-one staff working with him.
- When an allegation of physical and verbal abuse was made against him on 5/21/2022, the ED had immediately met with him to investigate the allegation.

Interviews on 6/7/2022 and 6/8/2022 with the Former Qualified Professional (FQP) revealed:
- She had been informed on the morning of 5/21/2022 that FC #2 reported to his Guardian that Staff #1 had grabbed him by the neck and choked him.
-The alleged choking occurred on 5/12/2022 and 5/14/2022.
- The Iris report was not submitted until 5/25/2022.

Interview from 6/1/2022 to 6/8/2022 with the ED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL041-903	A. BUILDING: _____ B. WING _____	R 06/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE UMBRELLA GROUP	4308 BRITLEY COURT GREENSBORO, NC 27406

(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 318	Continued From page 7 revealed: - On 5/21/2022, FC #2 alleged that Staff #1 had choked him. - The FQP had learned of the allegation on 5/21/2022. - The FQP was supposed to have entered the allegation against Staff #1 into an IRIS report within 24 hours. - The FQP had asked for her assistance with entering the IRIS report on 5/24/2022. - The FQP was terminated on 5/26/2022. - The FQP had not provided her with the code necessary to make corrections on the IRIS report. - The report was not actually entered into IRIS until 5/26/2022 after she was able to get a code from someone from the LME/MCO responsible for viewing IRIS reports.	V 318		
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	V 536	27E .0107 Client Rights - Training on Alt to Rest. Int. All incoming staff / new staff will be trained on training on alternatives to restrictive interventions (NCI+) before the hire/start date. All existing staff will be trained on alternatives to restrictive interventions (NCI+) within 30 days of the expiration of current training. As a part of onboarding, Administrative staff will complete the final review and sign-off on the audited personal files prior to hire/ start dates to ensure that the staff is in compliance. Administrative staff will review all current staff training and establish a future schedule for all expiring training. Staff will review notifications expiring training via email.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL041-903	A. BUILDING: _____ B. WING _____	R 06/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE UMBRELLA GROUP	4308 BRITLEY COURT GREENSBORO, NC 27406

(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 536	Continued From page 8 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 activities which directly oppose or replace	V 536	Administrative staff will track and monitor the training schedule monthly to ensure compliance. Training will occur within the next 45 days, no later than August 07, 2022. Administrative Staff will provide training and assure that reporting is completed within the allotted time for all required reporting agencies.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL041-903	A. BUILDING: _____ B. WING _____	R 06/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE UMBRELLA GROUP	4308 BRITLEY COURT GREENSBORO, NC 27406

(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 536	Continued From page 9 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. (6) Trainers shall have coached experience	V 536		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL041-903	A. BUILDING: _____ B. WING _____	R 06/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE UMBRELLA GROUP	4308 BRITLEY COURT GREENSBORO, NC 27406

(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 536	Continued From page 10 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: Based on record review and interview, the facility	V 536		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL041-903	A. BUILDING: _____ B. WING _____	R 06/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE UMBRELLA GROUP	4308 BRITLEY COURT GREENSBORO, NC 27406

(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 536	Continued From page 11 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 revealed: - Hire date: 12/1/2008 - Only her most recent NCI+ training certificate was present. - 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 needed it. - Staff #1 had been sick for a period of time, so	V 536		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL041-903	A. BUILDING: _____ B. WING _____	R 06/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE UMBRELLA GROUP	4308 BRITLEY COURT GREENSBORO, NC 27406

(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 536	Continued From page 12 he missed his original scheduled refresher training. - Staff #2 was new, so he did not have his initial training in NCI+ 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 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 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.	V 537	27E .0108 Client Rights - Training in Sec Rest & ITO All incoming staff / new staff will be trained on Seclusion, Physical Restraint, and Isolation Time-out (NCI+) before the hire/start date. All existing staff will be trained on Seclusion, Physical Restraint, and Isolation Time-out Seclusion, Physical Restraint, and Isolation Time-out (NCI +) within 30 days of the expiration of current training. As a part of onboarding, Administrative staff will complete the final review and sign-off on the audited personal files prior to hire/ start dates to ensure that the staff is in compliance. Administrative staff will review all current staff training and establish a future schedule for all expiring training. Staff will review notifications expiring training via email. Training will occur immediately and no later than August 07, 2022.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL041-903	A. BUILDING: _____ B. WING _____	R 06/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE UMBRELLA GROUP	4308 BRITLEY COURT GREENSBORO, NC 27406

(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 13 (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 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.	V 537	Administrative Staff will provide training and ensure that all staff remain in compliances with training requirement.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL041-903	A. BUILDING: _____ B. WING _____	R 06/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE UMBRELLA GROUP	4308 BRITLEY COURT GREENSBORO, NC 27406

(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 14 (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 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	V 537		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL041-903	A. BUILDING: _____ B. WING _____	R 06/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE UMBRELLA GROUP	4308 BRITLEY COURT GREENSBORO, NC 27406

(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 15 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. (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.	V 537		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL041-903	A. BUILDING: _____ B. WING _____	R 06/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE UMBRELLA GROUP	4308 BRITLEY COURT GREENSBORO, NC 27406

(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 16 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 was not completed until 5/12/2022. Review on 6/2/2022 of the ED's employee record revealed: - Hire date: 12/1/2008 - Only her most recent NCI+ Restrictive training certificate was present. - Formal refresher training in NCI+ Restrictive was completed on 5/12/2022. 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	V 537		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL041-903	A. BUILDING: _____ B. WING _____	R 06/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE UMBRELLA GROUP	4308 BRITLEY COURT GREENSBORO, NC 27406

(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		