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	MHL011-420	A. BUILDING: _____ B. WING _____	R 06/02/2022

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V 000	INITIAL COMMENTS An annual, complaint and follow up survey was completed on 6/2/22. The complaint (Intake # NC189153) was substantiated. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600F Supervised Living for Individuals of all Disability Groups/Alternative Family Living. This facility is licensed for 3 and currently has a census of 3. The survey sample consisted of audits of 3 current clients.	V 000		
V 117	27G .0209 (B) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (b) Medication packaging and labeling: (1) Non-prescription drug containers not dispensed by a pharmacist shall retain the manufacturer's label with expiration dates clearly visible; (2) Prescription medications, whether purchased or obtained as samples, shall be dispensed in tamper-resistant packaging that will minimize the risk of accidental ingestion by children. Such packaging includes plastic or glass bottles/vials with tamper-resistant caps, or in the case of unit-of-use packaged drugs, a zip-lock plastic bag may be adequate; (3) The packaging label of each prescription drug dispensed must include the following: (A) the client's name; (B) the prescriber's name; (C) the current dispensing date; (D) clear directions for self-administration; (E) the name, strength, quantity, and expiration date of the prescribed drug; and	V 117		

DHSR - Mental Health
JUL 28 2022
Lic. & Cert. Section

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V 117	Continued From page 1 (F) the name, address, and phone number of the pharmacy or dispensing location (e.g., mh/dd/sa center), and the name of the dispensing practitioner. This Rule is not met as evidenced by: Based on observations, record reviews and interviews the facility failed to ensure the packaging and labeling of each prescription drug dispensed contained clear directions for administration affecting 1 of 3 clients (Client #1). The findings are: Observation on 5/23/22 at 11:30AM and 6/1/22 at 2:30PM of the medication box for Client #1 revealed weekly pill packs for daily administration of medications. There was a label at the top of each week listing the drug name, description/appearance, quantity, instructions and prescriber. Each pill pack was labeled with the administration time and name of medication(s) contained in each pack. -Morning pill pack labeled: Finasteride 5mg (milligram); Metformin HCl 500mg; Sertraline 100mg; Quetiapine 50mg; Divalproex sodium 500mg DR (delayed release). -2PM pill pack labeled: Quetiapine 50mg; Divalproex Sodium 500mg DR. -6PM pill pack labeled: Quetiapine 300mg -Bedtime Pill Pack #1 labeled: Trazadone HCl 150mg; Divalproex Sodium 500mg DR. -Bedtime Pill Pack #2 labeled: Melatonin 5mg; Atorvastatin 10mg; Gabapentin 400mg. In addition to the pill packs were bottles of PRN	V 117		

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V 117	Continued From page 2 (as needed) medications including: -Dicyclomine 10mg (blue capsule with Mylan 1610). -Benztropine 1mg (white oval tablet with identifying letters APO appearing to be rubbed or worn off). -Hydroxyzine 50mg (green/white capsule with E615). -Ibuprofen 800mg (large white oval with I8). -Haloperidol 10mg (round pink tablet scored with AC on top of score and 155 below). Review on 6/1/22 of Medical Notes from County Detention Center (jail) for Client #1 revealed: - " ...5/12/22 21:10 (9:10pm) ...[Staff #2] dropped off medication earlier for the patient in prepackaged pills packs for bedtime medications. The baggie contained 3 pill packs: Pack 1: Gabapentin 400mg (4 capsules) pack intact. Pack 2: Trazadone HCl 150mg (2 pills) and Divalproex Sodium 500mg DR (1 pill) pack intact. Pack 3: Labeled as Melatonin 5mg, Atorvastatin 10mg, Gabapentin 400mg Pack has clearly been tampered with and per pill identifier search, contains the following medications: -Haloperidol 10mg tablets (2 pills) -Ampyra 10mg (1 pill) -Loxapine Succinate 25mg capsules (2 capsules) -Gabapentin 400mg (4 capsules) -Unidentified white pill with no visible markings, may be melatonin (2 pills) -2 white oval shaped pills with the markings scraped off-unable to positively identify using online search but can rule out atorvastatin as these pills are pre-scored for breaking tablets and atorvastatin does not come in pre-scored tablets. On the phone conversation, the man who	V 117	Staff will retake Medication administration training inperson with a nurse as well as our online 4 part Medication training on relias to ensure in the future they are trained to know how to properly transport Medications from one facility to another.	

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V 117	Continued From page 3 answered stated that the extra pills in the opened packet are 'PRN meds' and that the patient need to take them to avoid any issues. RN (registered Nurse) informed the man that we will not administer any medications without them being in original packaging and since these have clearly been tampered with they will not be offered to the patient while he is here ..." Record review on 5/20/22 for Client #1 revealed: -Date of admission-8/27/19 -Diagnoses-Paraphilia, Moderate Intellectual Disability, Hyperlipidemia and history of childhood leukemia, testicular cancer and seizure disorder. -Incarcerated in local county detention center from 5/12/22-5/13/22. -Physician ordered medications on 5/19/21 included: -Finasteride 5mg (urinary retention) 1 tablet every AM. -Sertraline HCL 100mg (antidepressant) 2 tablets every morning. -Gabapentin 400mg (anticonvulsant), 4 capsules at bedtime. -Melatonin 5mg (sleep) 2 tablets at bedtime. -Trazadone HCL 150mg (sleep) 2 tablets at bedtime. -Divalproex Sodium 500mg (behavior/seizures) 1 tablet 3 times daily. -Quetiapine Fumarate ER 300mg (antipsychotic) 1 tablet at 6pm. -Haloperidol 10mg (antipsychotic) 1 tablet 3 times daily PRN for agitation (may repeat dose in 15-30 minutes if first dose not effective). -Hydroxyzine Pamoate 50mg (antianxiety) 1 capsule 3 times daily PRN for anxiety. -Benztropine 1mg (restlessness, pacing, drooling) 1 tablet twice daily PRN. -Quetiapine Fumarate 50mg (antipsychotic) 1 tablet twice daily at 8am and noon ordered	V 117		

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V 117	Continued From page 4 6/29/21. -Metformin HCL 500mg (diabetes) 1 tablet once daily ordered 11/17/21. -Atorvastatin Calcium 10mg (high cholesterol) 1 tablet once daily ordered 2/23/22. -Dicyclomine 10mg (dyspepsia) 1 capsule every 8 hours PRN ordered 10/21/21. -Ibuprofen 800mg (pain) 1 tablet every 12 hours PRN ordered 10/21/21. Record review on 5/20/22 for Client #3 revealed: -Date of admission-6/13/18 -Diagnoses- Profound Hearing Loss, Moderate Intellectual Disability, Attention Deficit Hyperactivity Disorder and Intermittent Explosive Disorder. Physician ordered medications included: -Loxapine Succinate 25mg (agitation) 1 capsule 3 times daily PRN ordered 3/16/21. Interview on 5/23/22 with Client #1 revealed: -"I didn't get any of my meds (medications) in jail." Interview on 5/23/22 with Staff #1 revealed: -She had put Client #1's evening packet medications in a zip lock baggie. She pulled the seal back to insert PRNs, 1 haloperidol and 2 hydroxyzine. The Jail staff said they couldn't give because the medications had been tampered with. Staff #2 returned to the jail with entire medication box and books with orders and MARs (medication administration record). The jail made copies of papers but still didn't give Client #1 his medications. -Gabapentin was previously packaged by itself with 4 capsules but was now included with other night medications. -She did not know what Ampyra was or where it came from. -She only put 2 medications in the pill pack that	V 117		

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V 117	Continued From page 5 Staff #2 first took to the jail in a baggie. Interview on 5/23/22 with Staff #2 revealed: -He took the baggie of medications to the jail on 5/12/22. He was told their psychiatrist would have to approve. He was told this was too many medications and they were not going to give these to Client #1. -He made another trip to the jail with Client #1's entire box of medications as well as the notebook with MARs and orders. Interview on 5/20/22 with the Qualified Professional revealed: -She was not aware the AFL (alternative family living) caregiver had taken medication to the jail for Client #1 nor what medications they had taken. -The AFL caregivers had medication/MAR issues previously and thought it all had -She would schedule both staff for medication retraining and would be monitoring more closely. This deficiency constitutes a recited deficiency. This deficiency is cross referenced into 10A NCAC 27G .0209(c) Medication Requirements (V118) for a Type B rule violation and must be corrected within 45 days.	V 117		
V 118	27G .0209 (C) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (c) Medication administration: (1) Prescription or non-prescription drugs shall only be administered to a client on the written order of a person authorized by law to prescribe drugs.	V 118		

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V 118	Continued From page 6 (2) Medications shall be self-administered by clients only when authorized in writing by the client's physician. (3) Medications, including injections, shall be administered only by licensed persons, or by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer medications. (4) A Medication Administration Record (MAR) of all drugs administered to each client must be kept current. Medications administered shall be recorded immediately after administration. The MAR is to include the following: (A) client's name; (B) name, strength, and quantity of the drug; (C) instructions for administering the drug; (D) date and time the drug is administered; and (E) name or initials of person administering the drug. (5) Client requests for medication changes or checks shall be recorded and kept with the MAR file followed up by appointment or consultation with a physician. This Rule is not met as evidenced by: Based on observation, record review and interviews, the facility failed to keep the MARs current and failed to follow the written order of a physician for 3 of 3 clients (Client #1, Client #2 and Client #3). The facility also failed to ensure medications were administered by persons trained by a registered nurse (RN) or other legally qualified person for 1 of 3 audited staff (Staff #1). The findings are:	V 118		

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V 118	Continued From page 7 Cross Reference: 10A NCAC 27G .0209(b) Medication Requirements (V117) Based on observations, record reviews and interviews the facility failed to ensure the packaging and labeling of each prescription drug dispensed contained clear directions for administration affecting 1 of 3 clients (Client #1). Record review on 5/20/22 for Client #1 revealed: -Date of admission-8/27/19 -Diagnoses-Paraphilia, Moderate Intellectual Disability, Hyperlipidemia and history of childhood leukemia, testicular cancer and seizure disorder. -Physician ordered medications included: -Medroxyprogesterone Acetate 150mg(milligram) (reduce sex drive) inject 1.5ml (milliliter) IM (intramuscular) every 2 weeks ordered 7/20/21. -Haloperidol 10mg (antipsychotic) 1 tablet 3 times daily PRN (as needed) for agitation (may repeat dose in 15-30 minutes if first dose not effective) ordered 5/19/21. -Hydroxyzine Pamoate 50mg (antianxiety) 1 capsule 3 times daily PRN for anxiety ordered 5/19/21. -Ibuprofen 800mg (pain) 1 tablet every 12 hours PRN ordered 10/21/21. Review on 5/23/22 of March 1- May 23, 2022 MARs for Client #1 revealed: -Medroxyprogesterone Acetate injection was initialed as given on 3/4/22, 3/18/22, 4/1/22, 4/15/22, 4/29/22, 5/14/22 by Staff #1. -Haloperidol was initialed as administered once on 4/18/22, 5/1/22-5/8/22 and twice on 4/10/22,4/13/22, 4/15/22, 4/19/22, 4/20/22, 4/21/22, 4/23/22. (23 doses) On 5/13/22 initials were circled but nothing was written on the back of the MAR.	V 118		

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V 118	Continued From page 8 -Hydroxyzine was initialed as administered once 4/1/22-4/17/22. (17 doses) On 5/13/22 and 5/14/22 initials were circled but nothing was written on the back of the MAR. -Ibuprofen was initialed as administered once 4/2/22, 4/4/22, 4/6/22, 4/7/22,4/9/22, and 5/14/22 and twice on 4/10/22, 4/17/22, 4/20/22, 4/23/22. (14 doses) -There was no indication on the MARs of the received injection site for Client #1 to indicate the standard practice of rotating injection sites. -There was no documentation on the back of the MAR to explain what time a PRN medication was given, why it was given or the response to medication. Record review on 5/20/22 for Client #2 revealed: -Date of admission-10/29/17 -Diagnoses- Autism, Physical and Sexual Abuse as Child, Impulse Control Disorder, Post Traumatic Stress Disorder and Moderate Intellectual Disability. -Physician ordered medications included: -Fluoxetine 40mg 2 capsules at bedtime ordered 4/15/22. Review on 5/23/22 of March 1- May 23, 2022 MARs revealed: -Fluoxetine had been administered daily 3/1/22-4/14/22 without an order. (55 doses) Record review on 5/20/22 for Client #3 revealed: -Date of admission-6/13/18 -Diagnoses- Profound Hearing Loss, Moderate Intellectual Disability, Attention Deficit Hyperactivity Disorder and Intermittent Explosive Disorder. -Physician ordered medications included: -Loxapine Succinate 25mg 1 capsule 3 times a day PRN for agitation ordered 3/16/21.	V 118		

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V 118	Continued From page 9 Review on 5/23/22 of March 1- May 23, 2022 MARs revealed: -Loxapine had been administered 4/6/22, 4/9/22, 4/11/22-4/22/22,4/26/22, 5/1/22-5/9/22 and twice on 4/23/22 and 5/10/22. (30 doses) -There was no documentation on the back of the MAR to explain what time a PRN medication was given, why it was given or the response to medication. Review on 5/23/22 of printed MAR form used for Clients #1, #2 and #3 revealed: -On the top of the back page: "Instructions: a. Put initial in appropriate box when medication given b. Circle initials when medication refused c. State reason for refusal on Nurse's Medication Notes d. PRN Med: Reason given and results should be noted on Nurse's Medication Notes." -"Administrator's Medication Notes" with columns below for "Date/Hour; Medication/Dosage; Reason; Results/Response; Hour/Initials." Review on 5/20/22 of Staff #1's record revealed: -Date of hire-10/29/17. -There was no specific training documentation for Staff #1 to inject IM medication for Client #1. Interview on 5/24/22 with Licensee's Training Nurse (registered nurse) revealed: -Provided medication administration and MAR training for the Licensee and their staff. She used a standard MAR form and created typical medications to train staff. -"I absolutely train on how to address PRNs on the MAR. I have a whole little worksheet on how to document use of PRNs." -Staff were to initial the front of the MAR and write	V 118	Staff was shown how to do it by the Nurse at the doctors office. QP also had Staff trained by REI's Nurse and she was issued a certificate	

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V 118	Continued From page 10 an explanation of why the PRN was given and the results. There were also instructions written on the preprinted MAR. -She did not routinely train staff to administer shots unless they needed specific training. -She had not trained Staff #1 to administer the intramuscular shot for Client #1 because her pharmacy did not prepare or dispense Client #1's medications. Interview on 5/23/22 with Client #1 revealed: -"When I get really upset/angry, I can take up to 3 PRNs." Interview on 5/23/22 with Staff #1 revealed: -She had been taught how to give Client #1 his Medroxyprogesterone shot but did not have documentation from the doctor. She put on gloves, cleaned Client #1's upper arm with alcohol wipe, drew the entire vile of medication into syringe then administered medication. She alternated arms every two weeks for his shot. -She gave Client #1 PRN Haldol when he became angry or aggressive. She waited an hour or 2 to determine if he needed another dose. Sometimes he asked for his PRN. -She gave Client #1 PRN Hydroxyzine when he became anxious. She could not explain specific behaviors Client #1 might present in order to receive this PRN. -Client #2 had been on Fluoxetine for a while but could not find an order earlier than 4/15/22. -She gave Client #3 PRN Loxapine when he became angry or aggressive. -She was aware she was supposed to complete the back of the MAR for PRNs she just had not done it. Review on 6/1/22 of 1st Plan of Protection signed 6/1/22 by the Qualified Professional revealed:	V 118	Staff re took Medication administration with Nurse as well as u part online relias Medication training to ensure the MAR is filled in Correctly. QP will go over MAR Monthly for 3 Months to ensure it is filled in Correctly.	

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V 118	Continued From page 11 "What immediate action will the facility take to ensure the safety of the consumers in your care? -Additional medication administration training with a nurse from [local] Pharmacy as well as a 4-part Relias medication training. Relias is a training program used by Reach for Independence (Licensee). -Additional bi-weekly Monitoring to ensure the MAR is filled in correctly and all medications are labeled and in the correct containers. -Check Medications at each monthly supervision to ensure everything is labeled and in the correct containers -Additional NCI+ (North Carolina Interventions) restrictive training that includes other techniques such as a two person assist from a seated position -Additional client specific training for [Staff #1], [Staff #2] and [Staff #3]. Describe your plans to make sure the above happens. -QP will set up the trainings and ensure [Staff #1], [Staff #2] and [Staff #3]., all attend them -QP will check the medications bi-weekly and at every monthly monitoring and consult the medication compliance officer if there are questions -QP will be notified every time a PRN is administered and the results of it." Review on 6/2/22 of 2nd Plan of Protection signed 6/2/22 by the Qualified Professional revealed: "What immediate action will the facility take to ensure the safety of the consumers in your care? -Additional medication administration training with a nurse from [local] Pharmacy as well as a 4-part Relias medication training. Relias is a training program used by Reach for Independence. This will be completed on June 10th.	V 118		

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V 118	Continued From page 12 -Additional bi-weekly Monitoring to ensure the MAR is filled in correctly and all medications are labeled and in the correct containers. This will be completed June 10th and every other Friday after that. -Check Medications at each monthly supervision to ensure everything is labeled and in the correct containers. This will be completed on June 10th and then every monthly supervision after that. -Additional NCI+ restrictive training that includes other techniques such as a two person assist from a seated position. This will be completed by June 2nd. -Additional client specific training for [Staff #1], [Staff #2] and [Staff #3]. This will be completed by June 8th. Describe your plans to make sure the above happens. -QP will set up the trainings and ensure [Staff #1], [Staff #2] and [Staff #3], all attend them -QP will check the medications bi-weekly and at every monthly monitoring and consult the medication compliance officer if there are questions -QP will be notified every time a PRN is administered and the results of it." The facility is an AFL with 3 clients primarily diagnosed with Moderate Intellectual Disability, Paraphilia, Autism, Physical and Sexual Abuse as Child, Impulse Control Disorder, Post Traumatic Stress Disorder, Profound Hearing Loss, Attention Deficit Hyperactivity Disorder and Intermittent Explosive Disorder. Client #1 received 6 shots intramuscularly, administered by Staff #1 who was not specifically trained. Client #1 and Client #3 received 70 doses of PRN Haloperidol, Hydroxyzine and Loxapine without any documentation as to what behaviors may have been exhibited in order to be administered	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL011-420	A. BUILDING: _____ B. WING _____	R 06/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAYTON HOME	115 TABERNACLE ROAD BLACK MOUNTAIN, NC 28711

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V 118	Continued From page 13 these medications, what time a dose was given nor what effect the medication had on the 2 clients. Client #2 was administered 55 doses of Fluoxetine without an order. In addition, Staff # 1 opened a pack of prepacked medications to insert additional medications (1 Haloperidol and 2 Hydroxyzine) and delivered to the local jail in a baggie without any instructions for Client #1. According to the jail's identification, 7 additional medications were included in the pack: 2 Haloperidol (PRN for Client #1); 2 Loxapine Succinate (Client #3's PRN); 1 Ampyra (unknown pill) and 2 white oval shaped pills with markings scrapped off (probable Benztropine PRN for Client #1). Therefore, this deficiency constitutes a Type B rule violation. If the violation is not corrected within 45 days, an administrative penalty of $200.00 per day will be imposed for each day the facility is out of compliance beyond the 45th day.	V 118		
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	V 537		

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	MHL011-420	A. BUILDING: _____ B. WING _____	R 06/02/2022

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V 537	Continued From page 14 volunteers shall complete training in the use of seclusion, physical restraint and isolation time-out and shall not use these interventions until the training is completed and competence is demonstrated. (c) A pre-requisite for taking this training is demonstrating competence by completion of training in preventing, reducing and eliminating the need for restrictive interventions. (d) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (e) Formal refresher training must be completed by each service provider periodically (minimum annually). (f) Content of the training that the service provider plans to employ must be approved by the Division of MH/DD/SAS pursuant to Paragraph (g) of this Rule. (g) Acceptable training programs shall include, but are not limited to, presentation of: (1) refresher information on alternatives to the use of restrictive interventions; (2) guidelines on when to intervene (understanding imminent danger to self and others); (3) emphasis on safety and respect for the rights and dignity of all persons involved (using concepts of least restrictive interventions and incremental steps in an intervention); (4) strategies for the safe implementation of restrictive interventions; (5) the use of emergency safety interventions which include continuous assessment and monitoring of the physical and psychological well-being of the client and the safe	V 537		

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V 537	Continued From page 15 use of restraint throughout the duration of the restrictive intervention; (6) prohibited procedures; (7) debriefing strategies, including their importance and purpose; and (8) documentation methods/procedures. (h) Service providers shall maintain documentation of initial and refresher training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcomes (pass/fail); (B) when and where they attended; and (C) instructor's name. (2) The Division of MH/DD/SAS may review/request this documentation at any time. (i) Instructor Qualification and Training Requirements: (1) Trainers shall demonstrate competence by scoring 100% on testing in a training program aimed at preventing, reducing and eliminating the need for restrictive interventions. (2) Trainers shall demonstrate competence by scoring 100% on testing in a training program teaching the use of seclusion, physical restraint and isolation time-out. (3) Trainers shall demonstrate competence by scoring a passing grade on testing in an instructor training program. (4) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (5) The content of the instructor training the service provider plans to employ shall be approved by the Division of MH/DD/SAS pursuant to Subparagraph (j)(6) of this Rule.	V 537		

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	MHL011-420	A. BUILDING: _____ B. WING _____	R 06/02/2022

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V 537	Continued From page 16 (6) Acceptable instructor training programs shall include, but not be limited to, presentation of: (A) understanding the adult learner; (B) methods for teaching content of the course; (C) evaluation of trainee performance; and (D) documentation procedures. (7) Trainers shall be retrained at least annually and demonstrate competence in the use of seclusion, physical restraint and isolation time-out, as specified in Paragraph (a) of this Rule. (8) Trainers shall be currently trained in CPR. (9) Trainers shall have coached experience in teaching the use of restrictive interventions at least two times with a positive review by the coach. (10) Trainers shall teach a program on the use of restrictive interventions at least once annually. (11) Trainers shall complete a refresher instructor training at least every two years. (k) Service providers shall maintain documentation of initial and refresher instructor training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcome (pass/fail); (B) when and where they attended; and (C) instructor's name. (2) The Division of MH/DD/SAS may review/request this documentation at any time. (l) Qualifications of Coaches: (1) Coaches shall meet all preparation requirements as a trainer. (2) Coaches shall teach at least three times, the course which is being coached.	V 537		

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	MHL011-420	A. BUILDING: _____ B. WING _____	R 06/02/2022

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V 537	Continued From page 17 (3) Coaches shall demonstrate competence by completion of coaching or train-the-trainer instruction. (m) Documentation shall be the same preparation as for trainers. This Rule is not met as evidenced by: Based on record reviews and interview, the facility failed to ensure 2 of 3 audited staff (Staff #2 and #3) demonstrated competence in the proper use of seclusion, physical restraint and isolation time out. The findings are: Review on 5/24/22 of video footage of Client #1's release from jail on 5/13/22 at 4:02PM revealed: -Staff #2 walked out of door with Client #1 following and Staff #3 following him. Staff #2 came down the stairs with books in his arms and opened the back door of the vehicle then handed books to the driver in the front seat. Client #1 stood outside the vehicle toward the front of the car while Staff #3, with his hands behind his back, stood very closely behind Client #1. Staff #3 moved from behind Client #1 to his side still standing closely. Client #1 backed away from the vehicle and Staff #3 followed. Client #1 pushed Staff #3 with both hands then swung his fist at Staff #3. When the swing missed Staff #3, Staff #3 pulled up his pants and positioned his body in a defensive position then met Client #1 attacking and appeared to try to grab Client #1's arms wrestling with him. They both appeared to trip over the curb and fall to the ground off balance. Client #1 fell into the mulch on the right side of his face while his body was across a concrete curb still wrestling with Staff #3 trying to grab his arms.	V 537	All Staff have been retrained in NCI+ as well as taught additional techniques by NCI+ trainer to assist when physical intervention is needed.	

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V 537	Continued From page 18 Staff #3 fell beside and facing Client #1 he continued to wrestle to gain control. Staff #2 walked over, grabbed Client #1's left arm and pulled Client #1 seated back to the sidewalk while Staff #3 was holding Client #1's right arm. Staff #2 then hooked his arms under both Client #1's arms from behind and Staff #3 picked up Client #1's legs. They carried Client #1 to the vehicle and put him in the back seat. Both staff then entered the same door of the large SUV (sport utility vehicle). Inside of the vehicle was not visible from the camera view. The car drove off. Interview on 5/23/22 with Client #1 revealed: -"When I was released from jail [Staff #3] was walking behind me. I pushed [Staff #3] in face and he took me down." Staff #3 held Client #1's arm behind his back and pushed him to the ground hitting his face on the ground. Once in the car Staff #3 kept hitting Client #1 in the face. Staff #3 told him 'I should have beat you up when you hit my mom'. (Referring to the incident that on 5/12/22 that got him arrested.) -Client #3 hit him while in the car. Client #1 reported he had blood all over t-shirt and on both sides of his face. The cut on his face was from Staff #3 hitting him not from falling on the ground. -Staff #1 and Staff #2 didn't say anything to Staff #3 for hitting him in the car. Interview on 5/23/22 with Staff #1 revealed: -On 5/12/22 approximately 2:45-3pm Client #3 was arguing/hitting Client #1. She took Client #1 with her to get her grandson a haircut for prom. Another community client and Client #1 were in barber shop, but the community client kept jumping around so they went to sit in the car. Client #1 was talking about Staff #1 and Staff #2 taking up for Client #3 and "getting madder and madder." The windows were down. Staff #1	V 537		

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V 537	Continued From page 19 turned around and told Client #1 to calm down and keep his seatbelt on. He hit her in the side of the head knocking her glasses off, reached outside window to open door and jumped out of the car. He ran around for a little bit and came back with a big rock that he threw at the car. A local store owner asked about calling the police to which Staff #1 said yes. The police came, handcuffed Client #1 and took to jail. -On 5/13/22, "I was driving to pick up [Client #1]. He attacked [Staff #3]; hit [Staff #3] and [Staff #3] took him down. The Sheriff's office called to see if my son was ok because they had seen the footage of release. [Client #1] did hit his face on the right side on the pavement when [Staff #3] took him down. Then [Staff #2] went over to assist 2 man hold to get him into the car. [Client #1] was still swinging when he got in the car." She did not see Staff #2 or Staff #3 hit him. -She took Client #1 to urgent care the next day on Saturday as his face was swollen. They prescribed an antibiotic and referred to local hospital for x-rays. -On Sunday she took Client #3 to local Emergency Room for face x-rays which showed nothing broken and discontinued antibiotic. Interview on 5/23/22 and 5/27/22 with Staff #2 revealed: -"This lady from the jail came down and said [Client #1] didn't want to come back and if he did he was gonna get another assault charge." They had left him in jail overnight to "help him cool off." The last time we picked him up from jail he ran up into the parking deck and was going to jump off. Client #1 said to him, "I'm not getting in that car; I'll get another charge." Staff #2 took the books to car, handed books to Staff #1, turned around and Client #1 was charging at Staff #3. "[Staff #3] had to put him down. He was still kicking and	V 537		

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	MHL011-420	A. BUILDING: _____ B. WING _____	R 06/02/2022

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V 537	Continued From page 20	V 537		

scratching. I got up under his arms to carry him to the car. [Staff #3] got his legs." Police called when they got home to see if they were ok. "The first time we picked him up from jail he ran and I had to chase him. I'm too old to chase after him." Client #1 was swinging at Staff #3. "[Staff #3] put him down and [Client #1] hit his face on the ground. [Client #1] was still trying to bite and scratch. He went face down. We grabbed him up and put him in the car still kicking, swinging, spitting." They kept Client #1 between Staff #2 and Staff #3. "[Client #3] hit him from the 3rd seat. [Staff #3] got [Client #3] calmed down but [Client #1] was still swinging. He pulled the glasses off my face. We were in the suburban. [Client #1] was sitting on seat with his knees up. [Staff #3] had his hands up to keep from getting hit." They did not hold his arms in the car. Gave him a PRN (as needed) when they got home.
-The way Client #1 was coming after him, if Staff #3 wasn't protecting himself he'd been knocked out.

Interview on 5/23/22 and 5/27/22 with Staff #3 revealed:
-Only worked with Client #3 when picking him up from jail.
-He typically worked with Client #3 in the community but was helping out his parents (Staff #1 and Staff #2).
-"[Client #1] told staff at the jail if they released him, he was going to catch another assault and they still released him." They waited at jail for 3 hours.
-"Mom had guardian on the phone and wanted to speak to [Client #1] but he refused." He then went toward Staff #3. Staff #3 stepped back and Client #1 tripped and fell on the curb. He sat up and Staff #3 and Staff #2 got a 2 person hold/assist held him under both arms. Staff #2

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	MHL011-420	A. BUILDING: _____ B. WING _____	R 06/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAYTON HOME	115 TABERNACLE ROAD BLACK MOUNTAIN, NC 28711

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V 537	Continued From page 21 held him from the back under arms and Staff #3 got his feet in the car. Client #1 was still spitting, cussing, trying to bite, hit. Client #3 hit Client #1 in the face from the back. Staff #3 got between Client #1 and Client #3 and signed to Client #3 to relax. Client #1 sat between Staff #3 and Staff #2 in backseat. Staff #3 and Staff #2 only used blocks. Client #1 calmed some after Client #3 hit him. He wasn't combative in the car. Staff #3 cleaned Client #1's head and applied first aid cream. "It didn't bleed a lot." -Staff #1 took him alone to urgent care and then to hospital. Interview on 5/25/22 with Instructor for NCI+ (North Carolina Interventions) revealed: -"[Staff #1, #2 and #3] were certified in a seated restraint." -"Sometimes you do what's needed in the moment. [Staff #1, #2 and #3] are quite good at what they do. They've done this for a long time." -"No current NCI involves a carry. In old NCI there was a carry. There is no take down anymore." -"There are specific guidelines to help get a client to the ground safely." -Depends a lot on how he got to the ground. After review of the video on 5/27/22 of the incident the NCI+ instructor revealed: -"Initially doesn't look like a take down." Continuous review however, "it does look like a takedown even though they appear to trip over the curb they continued to wrestle on the ground. They used an old technique for carry. They used their survival skills. Carries are no longer taught." -Did not appear to be an aggressive take down as the "client was still flailing." -"Take down is not allowed and an unfortunate use of the term."	V 537		

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CLAYTON HOME	115 TABERNACLE ROAD BLACK MOUNTAIN, NC 28711

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V 537	Continued From page 22 -Once the client was down, Staff should have released, regrouped and dealt with the specific situation including monitoring. Interview on 5/20/22 and 5/26/22 with the Qualified Professional (QP) revealed: -Client #1 had guardianship with a local Department of Social Services. He has had previous arrests for Absence without Leave and breaking/entering. -She had completed IRIS (Incident Response Improvement System) with her understanding of the events. Staff #2 and Staff #3 had used 2 person assist to car from jail. -What got him in jail on 5/12/22, Client #1 and Client #3 were arguing so Staff #1 took Client #1 with her to get grandson haircut. Client #1 jumped out of the car threw a rock at the car. Police were called and he was arrested (property damage and assault on female). Staff #1 called the QP that Thursday night to report Client #1 was in jail and picked him up Friday night. Client #1 was picked up in 2 person hold (by Staff #2 and Staff #3) and fell on the curb. -"[Client #1] is extremely manipulative. He doesn't tell the truth and is always trying to get something he wants." -He has been there 4 years and had a "history of pretty bad stuff." She never had anyone else complain of mistreatment. -Staff #3 never had to document on Client #1 so he did not sign off having client specific training on Client #1. -Staff #3 is their son and provides community networking for Client #3. Review on 6/1/22 of 1st Plan of Protection signed 6/1/22 by the Qualified Professional revealed: "What immediate action will the facility take to ensure the safety of the consumers in your care?	V 537		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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V 537	Continued From page 23 -Additional medication administration training with a nurse from [local] Pharmacy as well as a 4-part Relias medication training. Relias is a training program used by Reach for Independence. -Additional bi-weekly Monitoring to ensure the MAR is filled in correctly and all medications are labeled and in the correct containers. -Check Medications at each monthly supervision to ensure everything is labeled and in the correct containers -Additional NCI+ (North Carolina Interventions) restrictive training that includes other techniques such as a two person assist from a seated position -Additional client specific training for [Staff #1], [Staff #2] and [Staff #3]. Describe your plans to make sure the above happens. -QP will set up the trainings and ensure [Staff #1], [Staff #2] and [Staff #3]., all attend them -QP will check the medications bi-weekly and at every monthly monitoring and consult the medication compliance officer if there are questions -QP will be notified every time a PRN is administered and the results of it." Review on 6/2/22 of 2nd Plan of Protection signed 6/2/22 by the Qualified Professional revealed: "What immediate action will the facility take to ensure the safety of the consumers in your care? -Additional medication administration training with a nurse from [local] Pharmacy as well as a 4-part Relias medication training. Relias is a training program used by Reach for Independence. This will be completed on June 10th. -Additional bi-weekly Monitoring to ensure the MAR is filled in correctly and all medications are labeled and in the correct containers. This will be	V 537		

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V 537	Continued From page 24 completed June 10th and every other Friday after that. -Check Medications at each monthly supervision to ensure everything is labeled and in the correct containers. This will be completed on June 10th and then every monthly supervision after that. -Additional NCI+ restrictive training that includes other techniques such as a two person assist from a seated position. This will be completed by June 2nd. -Additional client specific training for [Staff #1], [Staff #2] and [Staff #3]. This will be completed by June 8th. Describe your plans to make sure the above happens. -QP will set up the trainings and ensure [Staff #1], [Staff #2] and [Staff #3], all attend them -QP will check the medications bi-weekly and at every monthly monitoring and consult the medication compliance officer if there are questions -QP will be notified every time a PRN is administered and the results of it." The facility is an AFL with 3 clients primarily diagnosed with Moderate Intellectual Disability, Paraphilia, Autism, Physical and Sexual Abuse as Child, Impulse Control Disorder, Post Traumatic Stress Disorder, Profound Hearing Loss, Attention Deficit Hyperactivity Disorder and Intermittent Explosive Disorder. On 5/12/22, Client #1 hit Staff #1 and damaged her car prior to Police arresting him for assault and property damage. Upon his release the following day, Client #1 still defiant, began having an altercation with Staff #3. Although Staff #3 was assisting his parents to keep Client #1 from running away as he had previously done when released from jail, Staff #3 had not received any client specific training for Client #1. When Client #1 began	V 537		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL011-420	A. BUILDING: _____ B. WING _____	R 06/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAYTON HOME	115 TABERNACLE ROAD BLACK MOUNTAIN, NC 28711

(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 25 assaulting Staff #3, they wrestled around until they both tripped over the curb and fell side by side into the mulch. On the ground and instead of releasing, Staff #3 continued to try to contain Client #1. Staff #2 then pulled Client #1 by his left arm back to the sidewalk. Again, instead of allowing Client #1 to remain seated on the sidewalk, Staff #2 picked up Client #1 under both arms from behind while Staff #3 picked up his legs and they carried Client #1 to the car. Neither wrestling on the ground or carrying a client are approved restrictive interventions of NCI+. Therefore, this deficiency constitutes a Type B rule violation. If the violation is not corrected within 45 days, an administrative penalty of $200.00 per day will be imposed for each day the facility is out of compliance beyond the 45th day.	V 537		