Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: R B. WING MHL0411110 07/11/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1401 SHERROD-WATLINGTON CIRCLE **WATLINGTON'S FAMILY CARE HOMES #3** GREENSBORO, NC 27406 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) V 000 INITIAL COMMENTS V 000 An annual and follow up survey was completed on 7/11/2022. 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 6 and has a census of 6. The survey sample consisted of audits of 3 current clients. V 108 27G .0202 (F-I) Personnel Requirements V 108 10A NCAC 27G .0202 PERSONNEL REQUIREMENTS (f) Continuing education shall be documented. (g) Employee training programs shall be provided and, at a minimum, shall consist of the following: (1) general organizational orientation; (2) training on client rights and confidentiality as delineated in 10A NCAC 27C, 27D, 27E, 27F and 10A NCAC 26B; (3) training to meet the mh/dd/sa needs of the client as specified in the treatment/habilitation plan: and (4) training in infectious diseases and bloodborne pathogens. (h) Except as permitted under 10a NCAC 27G .5602(b) of this Subchapter, at least one staff member shall be available in the facility at all times when a client is present. That staff member shall be trained in basic first aid including seizure management, currently trained to provide cardiopulmonary resuscitation and trained in the Heimlich maneuver or other first aid techniques such as those provided by Red Cross, the American Heart Association or their equivalence for relieving airway obstruction. Division of Health Service Regulation LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE (X6) DATE

STATE FORM

AUG 17 2022

PRINTED: 07/15/2022

Division of Health Service Regulation STATEMENT OF DEFICIENCIES FORM APPROVED (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING: COMPLETED MHL0411110 B. WING .. R NAME OF PROVIDER OR SUPPLIER 07/11/2022 STREET ADDRESS, CITY, STATE, ZIP CODE WATLINGTON'S FAMILY CARE HOMES #3 1401 SHERROD-WAT LINGTON CIRCLE GREENSBORO, NC 27406 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX ID PROVIDER'S PLAN OF CORRECTION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PREFIX. (EACH CORRECTIVE ACTION SHOULD BE (X5) CROSS-REFERENCED TO THE APPROPRIATE TAG COMPLETE DATE DEFICIENCY) V 108 Continued From page 1 V 108 (i) The governing body shall develop and implement policies and procedures for identifying, reporting, investigating and controlling infectious and communicable diseases of personnel and clients. This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to ensure staff were currently trained in basic first aid and cardiopulmonary resuscitation (CPR) affecting 1 of 3 audited staff (#2). The findings are: Review on 7/11/2022 of Staff #2's employee record reveled: - Hire date: 11/1/2021 - No documentation of training in first aid or CPR was present. Interview on 7/11/2022 with staff #2 revealed: - She had been trained in first aid and CPR training prior to working at the facility. - She was scheduled for refresher training in first aid and CPR soon. - She thought that her first aid and CPR training was up to date. Interview on 7/11/2022 with the Licensee/Qualified Professional revealed: - Scheduling of staff trainings had been delayed due to staffing shortages and complications in getting trainers during the Covid-19 pandemic. - She did have staff trainings scheduled within the next week.

Division of Health Service Regulation
STATEMENT OF DEFICIENCIES (X1) P

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			, N. BOIEBING		R
		MHL0411110	B. WING		07/11/2022
NAME OF F	PROVIDER OR SUPPLIER		DRESS, CITY, S		
WATLING	TON'S FAMILY CARE HO	MES #3	ORO, NC 27	NGTON CIRCLE 406	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT 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 APPROPR DEFICIENCY)	BE COMPLETE
V 131	Continued From page	2	V 131		
V 131	G.S. 131E-256 (D2) H Verification	ICPR - Prior Employment	V 131		
	REGISTRY (d2) Before hiring health care facility or shealth care facility shade Personnel Registry and of access in the approach access in the approach.  This Rule is not met a	s evidenced by: w and interview, the facility ealth Care Personnel to hire affecting 1 of 3 findings are:			
	record revealed: - Hire date: 11/1/2021 - Documentation that the accessed until 7/10/203	ne HCPR was not			
V 133	G.S. 122C-80 Criminal	History Record Check	V 133		
	G.S. §122C-80 CRIMIN CHECK REQUIRED FO	NAL HISTORY RECORD OR CERTAIN			

Division of Health Service Regulation

Division of Health Service Regulation

	NT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION		SURVEY
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		MHL0411110	B. WING		07	/11/2022
	PROVIDER OR SUPPLIER	1401 SHEE		TATE, ZIP CODE		
WAILIN	GTON'S FAMILY CARE HO		ORO, NC 27	406		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
V 133	APPLICANTS FOR E  (a) Definition As use "provider" applies to a program and any providevelopmental disabiliservices that is licensed Chapter.  (b) Requirement An provider licensed under applicant to fill a positiapplicant to have an oconditioned on conserciminal history record the applicant has been less than five years, the is conditioned on conserciminal history record national criminal history record section. Except as other working as applicant, employ an applicant working and provided the conditional offer of shall submit a request Justice under G.S. 114 criminal history record section or shall submit entity to conduct a State check required by this state of the conditional offer of shall submit a request subsection or shall submit entity to conduct a State check required by this state of the conditional offer of shall submit and the conditional offer of shall submit a request subsection or shall submit entity to conduct a State check required by this state of the conditional offer of shall submit entity to conduct a State check required by this state of the conditional of the conditional offer of shall submit entity to conduct a State check required by this state of the conditional of the conditiona	MPLOYMENT.  ded in this section, the term in area authority/county rider of mental health, ity, and substance abuse able under Article 2 of this  offer of employment by a per this Chapter to an on that does not require the occupational license is at to a State and national check of the applicant. If in a resident of this State for iten the offer of employment eent to a State and national check of the applicant. The ty record check shall applicant's fingerprints. If in a resident of this State for in the offer is conditioned criminal history record A provider shall not the refuses to consent to a check required by this perwise provided in this business days of making employment, a provider to the Department of -19.10 to conduct a check required by this a request to a private the criminal history record section. Notwithstanding the partment of Justice shall tional criminal history oyment positions not 105-277 to the	V 133	DEF(CIENCY)		
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Division of Health Service Regulation PRINTED: 07/15/2022 FORM APPROVED STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING: COMPLETED MHL0411110 B. WING R NAME OF PROVIDER OR SUPPLIER 07/11/2022 STREET ADDRESS, CITY, STATE, ZIP CODE WATLINGTON'S FAMILY CARE HOMES #3 1401 SHERROD-WATLINGTON CIRCLE GREENSBORO, NC 27406 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL ID PROVIDER'S PLAN OF CURRECTION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX (EACH CORRECTIVE ACTION SHOULD BE (X5) CROSS-REFERENCED TO THE APPROPRIATE TAG COMPLETE DATE DEFICIENCY V 000 INITIAL COMMENTS V 000 An annual and follow up survey was completed on 7/11/2022. 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 6 and has a census of 6. The survey sample consisted of audits of 3 current clients. V 108 27G .0202 (F-I) Personnel Requirements Administrator will munitor Eacilities V 108 training in basic firstaid and 10A NCAC 27G .0202 PERSONNEL REQUIREMENTS cardio pulmary resuscitation (f) Continuing education shall be documented. (CPA) more closely ensuring that training certificates do not expire within 2 year 8/8/20 time frame. (g) Employee training programs shall be provided and, at a minimum, shall consist of the following: (1) general organizational orientation; (2) training on client rights and confidentiality as delineated in 10A NCAC 27C, 27D, 27E, 27F and Administrator and 1st A.d/CPR 10A NCAC 26B: (3) training to meet the mh/dd/sa needs of the trainer were not able to client as specified in the treatment/habilitation Complete dates until Monday, (4) training in infectious diseases and August 18th, 2022 Completion Date. bloodborne pathogens. (h) Except as permitted under 10a NCAC 27G .5602(b) of this Subchapter, at least one staff member shall be available in the facility at all times when a client is present. That staff member shall be trained in basic first aid including seizure management, currently trained to provide cardiopulmonary resuscitation and trained in the Heimlich maneuver or other first aid techniques such as those provided by Red Cross. the American Heart Association or their

equivalence for relieving airway obstruction. Division of Health Service Regulation

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

TITLE

(X6) DATE

Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: \_\_ R B. WING MHL0411110 07/11/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1401 SHERROD-WATLINGTON CIRCLE **WATLINGTON'S FAMILY CARE HOMES #3** GREENSBORO, NC 27406 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) V 108 | Continued From page 1 V 108 (i) The governing body shall develop and implement policies and procedures for identifying, reporting, investigating and controlling infectious and communicable diseases of personnel and clients. This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to ensure staff were currently trained in basic first aid and cardiopulmonary resuscitation (CPR) affecting 1 of 3 audited staff (#2). The findings are: Review on 7/11/2022 of Staff #2's employee record reveled: - Hire date: 11/1/2021 - No documentation of training in first aid or CPR was present. Interview on 7/11/2022 with staff #2 revealed: - She had been trained in first aid and CPR training prior to working at the facility. - She was scheduled for refresher training in first aid and CPR soon. - She thought that her first aid and CPR training was up to date. Interview on 7/11/2022 with the Licensee/Qualified Professional revealed: - Scheduling of staff trainings had been delayed due to staffing shortages and complications in getting trainers during the Covid-19 pandemic. - She did have staff trainings scheduled within the next week.

STATEIV	on of Health Service Reg MENT OF DEFICIENCIES AN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTH	PLE CONSTRUCTION	FORM APP
		IDENTIFICATION NUMBER:		G:	(X3) DATE SURVEY COMPLETED
		MHL0411110	B. WING		R
NAME O	F PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY S	7.00	07/11/202
WATLIN	NGTON'S FAMILY CARE H	OMES #3 1401 S	HERROD-WATEL	INGTON CIRCLE	
(X4) ID		GREEN	NSBORO, NC 27	406	
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V 13	Continued From page	2	V 131	DET IOIENCY)	
V 13	G.S. 131E-256 (D2) F Verification	ICPR - Prior Employment	V 131		
	G.S. §131E-256 HEAI REGISTRY	LTH CARE PERSONNEL			
	(d2) Before hiring hea	th care personnel into a			
	ricalti care facility or s	ervice every employer at -			-
	modifii care racility sha	Il access the Health Care d shall note each incident			
	of access in the approp	priate business files.			,
			V131	Administrators will acco	ess the
				Health Care Persons prior or before his Administrator will documentation of Ho	rel Registry
				prior or before his	ina
	This Pulo is material			Administrator will	le co
	This Rule is not met as	and interview, the facility	1	danni tati	PRin 7/11
	lailed to access the Hea	alth Care Personnel		abcumentation of AC	tkin 4
	Registry (HCPR) prior to	hire affecting 1 of 3		Staff file and rev	new
	audited staff (#2). The t	findings are:		file every 6 month	15,
and the same of th	Review on 7/11/2022 of record revealed:	staff #2's employee		.,	
	- Hire date: 11/1/2021				
	- Documentation that the	HCPR was not			
	accessed until 7/10/2022	2.			
	Interview on 7/11/2022 w	vith the			
	Licensee/Qualified Profe	ssional revealed:	Red Water age		
5	she was hired but did not	HCPR for Staff #2 before know where the printout			
C	confirming this was at.	ow where the printout			
V 133	G.S. 122C-80 Criminal H	story Record Check	V 133		
0	G.S. §122C-80 CRIMINA CHECK REQUIRED FOR	L HISTORY RECORD			Will depth of the control of the con

STATEME	n of Health Service Rec NT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	D/01		FO	RM APPRO
	TOP CORRECTION	IDENTIFICATION NUMBER:	(X2) MULTIPLE	CONSTRUCTION	(X2) DA7	T OLIN
			A. BUILDING: _			E SURVEY IPLETED
		MHL0411110	B. WING			
AME OF	PROVIDER OR SUPPLIER				0	R 7/11/2022
		STREET	ADDRESS, CITY STAT	E, ZIP CODE	1 0	1111/2022
AAILING	STON'S FAMILY CARE H	OMES #3 1401 SH	ERROD-WATLING	TON CIRCLE		
(X4) ID	CHAMAGNA	GREENS	SBORO, NC 27406	i		
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V 133	Continued From page	3		DEFICIENCY)		
			V 133			1
	APPLICANTS FOR E	MPLOYMENT.				
	"provider""	ed in this section, the term				
	bigainel applies to a	n area authority/count.				
	program and any providevelopmental disability	ider of mental health,				
	services that is license	ty, and substance abuse able under Article 2 of this				
1	Chapter.	ible under Article 2 of this				
		offer of employment by a				
	provider licensed unde	r this Chanter to an				
1	applicant to fill a position	on that does not require #				
1	applicant to have an oc	Cupational licence is				
1.5	conditioned on consent	to a State and notional				
1 '	chillinal history record	check of the applicant is			1	
1 5	applicant has been	a resident of this State for				
	cos man live years, the	on the offer of employment				
1	s conditioned on conse	nt to a State and notice-				
	national criminal bist	check of the applicant. The				
iı	national criminal history	record check shall				
ti	he applicant has been	pplicant's fingerprints. If a resident of this State for			İ	
fi	ve years or more, then	the offer is conditioned				
U	in consent to a State cr	minal history record				
C	neck of the applicant. A	provider shall not			-	
1 6	riploy an applicant who	refuses to concept to a				
01	minial instury record cr	leck required by this				
30	Except as other	Nise provided in this				
SE	ibsection, within five bi	Isiness days of makin-				
LII	e conditional offer of er	nnlovment a provider				
Ju	nall submit a request to stice under G.S. 114-1	the Department of	1			
cri	minal history record ch	9.10 to conduct a			1	
se	minal history record ch ection or shall submit a	required by this	diament of the second of the s			
en	tity to conduct a State	Criminal history reserve			1	
CIT	eck required by this sec	ction Notwithstanding				
G.,	<ol> <li>114-19.10, the Depa</li> </ol>	rtment of Justice shall				
161	urn the results of nation	nal criminal history				
rec	ora cnecks for employi	ment positions not				
					1	
CO	ered by Public Law 10 partment of Health and	5-277 to the				

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STALFINE	of Health Service Re				FOR	ED: 07/15/202: RM APPROVE
AND PLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION		
		IDENTIFICATION NUMBER:	A. BUILDING:	SHATKACTION	(X3) DATE	SURVEY
					COMP	PLETED
		MHL0411110	B. WING			R
IAME OF	PROVIDER OR SUPPLIER					11/2022
		STREET	ADDRESS, CITY, STAT	E. ZIP CODE	7 011	11/2022
VATLING	STON'S FAMILY CARE H	OMES #3 1401 SH	ERROD-WAT LING	TON CIPCI F		
		GREENS	BORO, NC 27406	CIRCLE		
(X4) ID PREFIX	SUMMARY S	IATEMENT OF DECISION				
TAG	(CACH DEFICIEN	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX	PROVIDER'S PLAN OF CORRE	CTION	(VE)
		1200 IDENTIFYING INFORMATION)	TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP	3111000	(X5) COMPLETE
1/122	0			DEFICIENCY)	ROPRIATE	DATE
V 133	Continued From pag	e 4	V 133			
	1		V 133			
	Criminal Records Ch	eck Unit. Within five				
	history of the pare	eipt of the national criminal				
	and Human Carriers	the Department of Health				
1	Unit shall notify the	Criminal Records Check				
1	information reprised	rovider as to whether the			1	
	of the applicant I	may affect the employability			ĺ	
1	or the applicant. In no	Case shall the reculto of the				
	with the provider D	ry record check be shared				
	Unon request verification	viders shall make available				
1	apon request verificati	Ion that a criminal history				
į	by this section A	leted on any staff covered				
	appropriate level	ity that has adopted an			Į.	ŀ
	the Division of Ci-	ance and has access to			1	- 1
	may conduct on partial	Information data bank				1
	may conduct on behalf	of a provider a State				
	section without the	check required by this				
	request to the Dane of	vider having to submit a				- 1
,	ase the countriel	ent of Justice. In such a			1	
	riminal history shall (	commence with the State				ì
8	ection within five lead	check required by this				1
C	ection within five busin	ness days of the				1
A	Il criminal biotom info	loyment by the provider.				-
n	rovider is confidential	mation received by the				- 1
6	ent to the applicant	and may not be disclosed,				
(6	of this section F-	as provided in subsection				-
(0	c) of this section. For p	urposes of this				1
h	ubsection, the term "pr	ivate entity" means a				1
cr	usiness regularly enga	ged in conducting				1
re	iminal history record of	necks utilizing public				1
10	cords obtained from a	State agency.				
re	Action If an applica	int's criminal history				
a	relevant offense 45	e or more convictions of				1
nf	the following factor	rovider shall consider all				
hir	e the applicant:	determining whether to				
1111	e trie applicant:					
(1)	The level and serious	ness of the crime.				
(2)	The date of the crime					
(3)	The age of the persor viction.	at the time of the	Ė			
COI	I VICTION.	, ·	1		į.	

	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _	CONSTRUCTION	(X3) DATE COMP	SURVE
		MHL0411110	B. WING			R
NAME OF I	PROVIDER OR SUPPLIER	STREET	000000		07/	11/202
WATLING	TON'S EARTH VOLUME	JIREE!	ADDRESS, CITY, STAT	E, ZIP CODE		
	STON'S FAMILY CARE H		ERROD-WATLING	TON CIRCLE		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	SBORO, NC 27406			
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V 133	Continued From pag	e 5	1/400	== 10/21(01)		
th (2	(4) The circumstance commission of the critical commission of the critical commission of the critical commission of the critical commission and the journal critical commission	es surrounding the ime, if known. en the criminal conduct of the duties of the position to be obation, parole, ployment records of the the crime was committed. ommission by the person of of a relevant offense alone employment; however, the considered by the provider. If the san applicant after levant factors, then the information contained in foord check that is relevant but may not provide a copy record check to the  A provider and an officer der that, in good faith, on shall be immune from the provider to employ an of information provided in ord check of the individual.	V 133	DEFICIENCY		
his	iminal offenses if the e story record check is r	employee's criminal				
(e	Relevant Offense A	Stion. As used in this section				
16	elevant offense" means	s a county, state, or f conviction or pending				
HIL	ilcument of a crime, wh	nether a misdemeanor or an individual's fitness to				
ha	ve responsibility for the	o orfoty and the section				
hei	sons needing mental	health, developmental abuse services. These				

PRINTED: 07/15/2022

Division of Health Service Regulation

TATEMEN	IT OF DEFICIENCIES				FOF	RM APPRO
ND PLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE	CONSTRUCTION		
		TONTON NUMBER:	A. BUILDING:			SURVEY
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ME OF P	ROVIDER OR SUPPLIER	CTDEET	10000			/11/2022
ATI INC	TONIO EARTH		ADDRESS, CITY, STAT			
AI LING	TON'S FAMILY CARE HO		ERROD-WATLING	TON CIRCLE		
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			ind	CROSS-REFERENCED TO THE AP DEFICIENCY)	PROPRIATE	DATE
V 133	Continued From page	6	7/455	SET TOTEMOT)		
- 1			V 133			
and the same of th	on sthe fall	ninal offenses set forth in				
	General State to	ticles of Chapter 14 of the				
	Issuing Manatan Cut-	cle 5, Counterfeiting and				
	Issuing Monetary Subs	situtes; Article 5A,				
	Article 6. Homicide: Art	e and Legislative Officers; ticle 7A, Rape and Other				
	Sex Offenses; Article 8	Assoults: Article 48				
	Kidnapping and Abduct	tion; Article 13, Malicious				
	Injury or Damage by Us	se of Explosive or				
1	Incendiary Device or M	aterial; Article 14, Burglary			1	
8	and Other Housebreaki	ings; Article 15, Arson and				
	ournings; Article	16. Larceny: Article 17	1		ļ	
r	Cobbery; Article 18, Em	bezzlement: Article 10				
	alse Pretenses and Ch	neats: Article 19A				
(	optaining Property or S	ervices by False or				
	raudulent Use of Credi	it Device or Other Means:				
1	rucie 198, Financial Tr	ansaction Card Crime				
A 2	Act; Article 20, Frauds;	Article 21, Forgery; Article				
D	6, Offenses Against Pu	blic Morality and				
Δ	Decency; Article 26A, Au	dult Establishments;				
2	9, Bribery; Article 31, M	Article 28, Perjury; Article				
0	office; Article 35, Offens	as Against the Buttle				
P	eace; Article 36A, Riots	es Against the Public				
Ar	rticle 39, Protection of N	Minors: Article 40			1	
Pr	rotection of the Family;	Article 59 Public				
Int	toxication; and Article 6	0. Computer-Related				
Cr	rime. These crimes also	include possession or				
Sa	lie of drugs in violation	of the North Carolina				
CC	ontrolled Substances A	ct. Article 5 of Chanter				
30	of the General Statute	S. and alcohol-related				
ОП	enses such as sale to t	underage persons in			-	
VIO	plation of G.S. 18B-302	or driving while				
imp	paired in violation of G.	S. 20-138.1 through				
	S. 20-138.5.					
(1)	plicant for employer	False Information Any				
ahl	plicant for employment	who willfully furnishes.	1			
SHE	THIRE OF Othorsing		į.		1	Ì
sup	opiles, or otherwise give employment application	es false information on				

Division of Health Service Regulation

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AND PLAN	NT OF DEFICIENCIES FOR CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRU	- ONWAPP
	o o o o o o o o o o o o o o o o o o o	IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY
			A. BUILDING:	COMPLETED
NIAAIT		MHL0411110	B. WING	R
NAME OF F	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE, ZIP CODE	07/11/202
WATLING	TON'S FAMILY CARE H	OMES #3 1401 SI	HERROD-WATLINGTON CIRCLE	
		GREEN	SBORO, NC 27406	E
(X4) ID PREFIX	SUMMARY S (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL		
TAG	NEGOLATORY DR	LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF PREFIX (EACH CORRECTIVE ACT TAG CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE COME
V 133	Continued From pag	e 7		
11000	criminal history recorshall be guilty of a Cl (g) Conditional Employemploy an applicant obtaining the results of check regarding the afollowing requirement (1) The provider shall prior to obtaining the acriminal history record subsection (b) of this single prior to cards as re (2) The provider shall criminal history record ousiness days after the conditional employments	d check under this section ass A1 misdemeanor. Dyment A provider may conditionally prior to of a criminal history record applicant if both of the sare met:  not employ an applicant applicant's consent for if check as required in section or the completed quired in G.S. 114-19.10. Submit the request for a check not later than five individual begins int. (2000-154, s. 4; 24, ss. 10.19D(c) (h):	Documentation ground check in Staff's file	tory check f hire or not record or than five ter employment  8/9/
Re re:	eview on 7/11/2022 of cord revealed: dire date: 11/1/2021 Documentation that a deck was not complete erview on 7/11/2022 vensee/Qualified Professee August 2006	n 5 days of making the loyment affecting 1 of 3 findings are:  staff #2's employee  criminal history record d until 7/10/2022.  with the essional revealed:  off #2 criminal history		
rec	ord check when she v	vas hired. original criminal history		

Division of Health Service Regulation

AND PLAN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(V2) DATE	OLIDA III.
			A. BUILDIN	G:	(X3) DATE COMP	LETED
NAME OF		MHL0411110	B. WING		1	R
	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, S	STATE. ZIP CODE	1 07/	11/2022
WATLING	TON'S FAMILY CARE H			INGTON CIRCLE		
(X4) ID	SUMMARY	GREEN	ISBORO, NC 27	7406		
PREFIX TAG	(CAUT DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CURRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	D.C.	(X COMP DA
V 133	Continued From page	8	V 133	The solution of the solution o		
The second secon	chiminal history, but he	or also checked Staff #2's e could not log into the ler to print out the original.	V 193			
	Interview on 7/11/2022 revealed: - He had checked Staf she was hired He tried to log into the	2 with the Licensee/Director				
1	III.	s - Training on Alt to Rest.	V 536	Watington's FC implemen	nts	
III (i)	or restrictive intervention  b) Prior to providing set isabilities, staff includir imployees, students or emonstrate competence completing training in contact ther strategies for creat hich the likelihood of in r injury to a person with coperty damage is prev  contact provider agencies shased on state competer	ement policies and te the use of alternatives ns. ervices to people with ng service providers; volunteers, shall the by successfully emmunication skills and ting an environment in naminent danger of abuse of disabilities or others or tented. nall establish training ncies, monitor for internal trate they acted on data		Watington's FC implement policies concerning the of alternatives to rest intervention within 5 of hire. Facility will ans staff complete a refreshment two years, hegardless of job fitte staff training will be be on state competencies monitor for internal con and demanstrate they on data gathered.  Completion Pate tacility still having trad	days ure training r, all used upliance can ac	ry
bel	easurable testing (writte havior) on those object	en and by observation of		finding trainer. Many higher out of business.	are	

KH2T11

PRINTED: 07/15/2022 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: COMPLETED A. BUILDING: R B. WING MHL0411110 07/11/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1401 SHERROD-WATLINGTON CIRCLE WATLINGTON'S FAMILY CARE HOMES #3 GREENSBORO, NC 27406 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) V 536 Continued From page 9 V 536 methods to determine passing or failing the (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: knowledge and understanding of the (1) people being served; recognizing and interpreting human (2)behavior; (3)recognizing the effect of internal and external stressors that may affect people with disabilities; strategies for building positive relationships with persons with disabilities; recognizing cultural, environmental and organizational factors that may affect people with disabilities: 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

(1)

positive behavioral supports (providing

means for people with disabilities to choose activities which directly oppose or replace

documentation of initial and refresher training for

Documentation shall include:

behaviors which are unsafe). (h) Service providers shall maintain

at least three years.

PRINTED: 07/15/2022 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:** COMPLETED A. BUILDING: B. WING MHL0411110 07/11/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1401 SHERROD-WATLINGTON CIRCLE WATLINGTON'S FAMILY CARE HOMES #3 GREENSBORO, NC 27406 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID 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 DATE DEFICIENCY) V 536 Continued From page 10 V 536 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. 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. 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. Acceptable instructor training programs (5)shall include but are not limited to presentation of: (A) understanding the adult learner;

(B)

(D)

course; (C)

performance; and

review by the coach.

methods for teaching content of the

Trainers shall have coached experience

Trainers shall teach a training program

methods for evaluating trainee

documentation procedures.

teaching a training program aimed at preventing, reducing and eliminating the need for restrictive interventions at least one time, with positive

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMPI	
						R
		MHL0411110	B. WING		07/	11/2022
NAME OF F	PROVIDER OR SUPPLIER		RESS, CITY, ST			
WATLING	TON'S FAMILY CARE HO	MES #3	ROD-WATLIN ORO, NC 274	NGTON CIRCLE 106		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETE DATE
V 536	aimed at preventing, red for restrictive interest annually.  (8) Trainers shat instructor training at less instructor training at less documentation of initial training for at least thre (1) Docume (A) who participal outcomes (pass/fail);  (B) when and with (C) instructor's regulated and review thing (A) Qualifications of Control (B) Coaches shat the course which is being (C) Coaches shat competence by complete train-the-trainer instruction shat as for trainers.	reducing and eliminating the erventions at least once all complete a refresher east every two years. Shall maintain al and refresher instructor ee years. Intation shall include: ated in the training and the there attended; and name. In a documentation any time. In a documentat	V 536			
	alternatives to restrictive providing services affect (#2); and failed to ensure					

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE S	
			7. BOILDING		F	2
		MHL0411110	B. WING		1	11/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	FATE, ZIP CODE		
WATLING	TON'S FAMILY CARE HO	MES #3		NGTON CIRCLE		
240.15	SUMMADVETA	TEMENT OF DEFICIENCIES	BORO, NC 274			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD) CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
V 536	Continued From page	12	V 536			
	audited staff (#1 & the	Licensee/Qualified				
	Professional (L/QP)).					
	Poviou on 7/11/2022	of staff #1's ampleuse				
	Review on 7/11/2022 record revealed:	or stan #15 employee			1	
	- Hire date: 8/8/2018					
	- Documentation that t					
	curriculum used by the alternatives to restricti					
	expired on 10/1/2021.					
	- No documentation of	refresher training in EBPI.				
	Review on 7/11/2022 of	of staff #2's employee				
	record revealed:					
	- Hire date: 11/1/2021	Andria - in EDDI				
	- No documentation of	training in EBPI.				
		of the L/QP's employee			100	
	record revealed: - Hire date: August 198	26				
	- Documentation that to					
	expired on 6/7/2019.	_				
	- No documentation of	refresher training in EBPI.				
	Interview on 7/8/2022	with Staff #1 revealed:				l
	- Her training on altern					
1	interventions was due to - She was scheduled to	for renewal.  o attend training over the		9		
	upcoming two weekens	9				
	Interview on 7/11/2022	with staff #2 save-1-1-				
1	- She had been trained					
	restrictive interventions					
		ng on EBPI was in 2012.				
	- Sne was scheduled fo	or training in EBPI soon.				
	Interview on 7/11/2022	with the				
	Licensee/Qualified Pro					-
	<ul> <li>She had not been able trainings in ERPI due to</li> </ul>	e to schedule staff  staffing shortages and				
	admings in LDF1 dde to	stanning shortages and				

STATEMEN	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(V2) AND TIPLE			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE	SURVEY
			A. BUILDING:			PLETED
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NAME OF T	2001//2017	MHL0411110	B. WING		07	R /11/2022
NAME OF F	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	ZIP CODE	7 01	111/2022
WATLING	TON'S FAMILY CARE H		ERROD-WATILING			
		GREEN	SBORO, NC 27406	TON CIRCLE		
(X4) ID PREFIX	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID			
TAG	REGULATORY OR	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	PROVIDER'S PLAN OF COM (EACH CORRECTIVE ACTION	RECTION	(X5
		IDENTIFICATION)	TAG	CROSS-REFERENCED TO THE	APPROPRIATE	COMP
V 536	Continued F			DEFICIENCY)		
V 000	Page 1 Tom page		V 536	- 20		1
1	audited staff (#1 & the	e Licensee/Qualified				
	Professional (L/QP)).	The findings are:				
Í						
	Review on 7/11/2022	of staff #1's employee		,		
	record revealed:	рібубб				Transmitted of the Control of the Co
	- Hire date: 8/8/2018					
	- Documentation that	training in EBPI (the				
	curriculum used by the	e facility for training on				
	alternatives to restricti	ve interventions) had				
	expired on 10/1/2021.				l,	
	<ul> <li>No documentation of</li> </ul>	refresher training in EBPI.	all manufactures and a second			
	Review on 7/11/2022	of staff #2's employee				
1	record revealed:	ne o simployee				
-	- Hire date: 11/1/2021					
-	No documentation of	training in EBPI.				
F	Review on 7/11/2022 a	of the L/QP's employee				
r	ecord revealed:	if the L/QP's employee				
	Hire date: August 198	36				
-	Documentation that tr	raining in EDDI L. I			1	
e	expired on 6/7/2019.	airling in EBPI had				
		refresher training in EBPI.				
		refresher training in EBPI.				
Ir	nterview on 7/8/2022 w	vith Staff #1 revealed:				
-	Her training on alterna	tives to restrictive				
in	iterventions was due fo	or renewal.				
	She was scheduled to	attend training over the		8		
uţ	pcoming two weekend	s.				
In	terview on 7/11/2022 v	with staff #2 rous -1 - 1				
- 5	She had been trained	on alternatives to			erus andre de la companya de la comp	
re	estrictive interventions	by a post operation				
- F	der most recent training	ng on EBPI was in 2012.				
- 8	She was scheduled for	training in EBPI soon.				
int	terview on 7/11/2022 v	vith the				
LIC	censee/Qualified Profe	essional revealed:	1			
- 5	She had not been able	to schedule staff				
ıra	urungs in EBPI due to s	staffing shortages and			1	

STATEMEN	IT OF DEFICIENCIES				FO	RM APPRO	
AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION				
		I SATION NOMBER:	A. BUILDING: _	(X3) DATE SURVEY COMPLETED			
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		MHL0411110	B. WING		1	R	
NAME OF P	ROVIDER OR SUPPLIER	CIDECT				07/11/2022	
WATLING	TONIC CAMERIA	SIREE	ADDRESS, CITY, STAT	E, ZIP CODE			
THE LINE	TON'S FAMILY CARE HO		ERROD-WATLING	TON CIRCLE			
(X4) ID	SUMMARY ST	GREEN	SBORO, NC 27406	5			
PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LOOK TO THE PROPERTY OF THE PROPERTY		ID PROVIDER'S PLAN OF CORR		OF OTHER		
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	PREFIX: TAG	LEACH CORRECTIVE ACTION CHOILE SE		(X5) COMPLE	
			170	CROSS-REFERENCED TO THE APP DEFICIENCY)	PROPRIATE	DATE	
V 536	Continued From page	13	VESS	DET TOILINGT)			
			V 536				
	complications in gettin Covid-19 pandemic.	g trainers during the					
	- She did have staff t	fall					
The state of the s	next week.	inings scheduled within the					
	WOOK.						
V 537	27E 0109 Client Di 11	_					
	ITO	s - Training in Sec Rest &	V 537				
	10A NCAC 27E .0108	TRAINING					
	SECLUSION, PHYSICA	TRAINING IN					
1	SOLATION TIME-OUT	TENESTRAINT AND			The second secon		
(	Seclusion, physical restraint and isolation     me-out may be employed only by staff who have						
					1		
	cen trained and have (	demonstrated					
C	ompetence in the prop	er use of and alternatives					
	rifese procedures. Fa	Cilities shall encure that					
- 3	di autitorized to emple	DV and terminate these					
þ	rocedures are retrained	and have demonstrated			the state of		
C	umpetence at least ann	nually					
(L	) Prior to providing dire	ect care to people with					
in	sabilities whose treatm	ent/habilitation plan			1		
Se	ervice providers, emplo	rentions, staff including					
VO	lunteers shall complete	yees, students or					
se	clusion, physical restra	int and isolation time-out					
an	d shall not use these in	nterventions uptil the			ĺ		
tra	ining is completed and	competence is					
ae	monstrated.						
(c)	A pre-requisite for tak	ing this training is					
ae	monstrating competend	ce by completion of					
ıra	ining in preventing, red	Ucing and eliminating					
uie	need for restrictive int	erventions					
(d)	The training shall be c	ompetency-based,			1		
mo	ude measurable learni	ng objectives,					
her	asurable testing (writte	n and by observation of					
nei	havior) on those objectives and measurable ethods to determine passing or failing the						
COLL	rse.	sing or failing the					
					1		
(e)	Formal refrecher train:	ng must be completed				1	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	(X3) DATE SURVEY COMPLETED					
		IDENTIFICATION NUMBER:	A. BUILDING		COMP						
						_ 1					
		ANUL DAMAGO	B. WING		1	R					
MHL0411110				1 07/	07/11/2022						
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE							
		NGTON CIRCLE									
WATLINGTON'S FAMILY CARE HOMES #3  GREENSBORO, NC 27406											
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C	OPPECTION	2/5					
PREFIX				(EACH CORRECTIVE ACTIO		(X5) COMPLETE					
TAG	REGULATORY OR I	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO TH		DATE					
				DEFICIENCY	)						
V 537	Continued From page	14	V 537								
		der periodically (minimum									
	annually).										
	(f) Content of the trai										
		loy must be approved by									
	the Division of MH/DE		1								
	Paragraph (g) of this										
		ng programs shall include,									
	but are not limited to,										
		formation on alternatives to									
	the use of restrictive in	TO TO BE A TO THE COLUMN TO A TO									
		n when to intervene									
		ent danger to self and									
	others);										
	(3) emphasis or	safety and respect for the									
	rights and dignity of all persons involved (using										
concepts of least restrictive interventions and											
	incremental steps in a	n intervention);									
	(4) strategies fo	r the safe implementation				1					
	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					1					
	restrictive intervention;					1					
	(6) prohibited pr	ocedures;				1					
	(7) debriefing strategies, including their										
	importance and purpo										
	<ul><li>(8) documentation methods/procedures.</li><li>(h) Service providers shall maintain documentation of initial and refresher training for</li></ul>										
	at least three years.										
	(1) Documentation shall include:										
	(A) who participated in the training and the										
outcomes (pass/fail);											
		here they attended; and									
	(C) instructor's r										
		of MH/DD/SAS may									
		cumentation at any time.									
		with the second									

PRINTED: 07/15/2022 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: COMPLETED A. BUILDING: R B. WING MHL0411110 07/11/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1401 SHERROD-WATLINGTON CIRCLE WATLINGTON'S FAMILY CARE HOMES #3 GREENSBORO, NC 27406 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) V 537 Continued From page 15 V 537 (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. Trainers shall demonstrate competence by scoring 100% on testing in a training program teaching the use of seclusion, physical restraint and isolation time-out. 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. 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. 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)

Rule. (8)

CPR. (9)

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

Trainers shall be currently trained in

Trainers shall have coached experience

PRINTED: 07/15/2022 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: COMPLETED A. BUILDING: \_ R B. WING MHL0411110 07/11/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1401 SHERROD-WATLINGTON CIRCLE WATLINGTON'S FAMILY CARE HOMES #3 GREENSBORO, NC 27406 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5)(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) V 537 Continued From page 16 V 537 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. (I) 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. (m) 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 reviews and interviews, 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 (#2); and failed to ensure formal refresher training was completed at least annually affecting