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V 000	INITIAL COMMENTS An annual and follow up survey was completed on November 17, 2022. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G 5600E Supervised Living for Adults with Substance Abuse Dependency. This facility is licensed for 8 and currently has a census of 1. The survey sample consisted of 1 current client and 2 former clients.	V 000		
V 105	27G .0201 (A) (1-7) Governing Body Policies 10A NCAC 27G .0201 GOVERNING BODY POLICIES (a) The governing body responsible for each facility or service shall develop and implement written policies for the following: (1) delegation of management authority for the operation of the facility and services; (2) criteria for admission; (3) criteria for discharge; (4) admission assessments, including: (A) who will perform the assessment; and (B) time frames for completing assessment. (5) client record management, including: (A) persons authorized to document; (B) transporting records; (C) safeguard of records against loss, tampering, defacement or use by unauthorized persons; (D) assurance of record accessibility to authorized users at all times; and (E) assurance of confidentiality of records. (6) screenings, which shall include: (A) an assessment of the individual's presenting problem or need; (B) an assessment of whether or not the facility can provide services to address the individual's	V 105		

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

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V 105	Continued From page 2	V 105		

This Rule is not met as evidenced by:
Based on record review and interview, the facility failed to develop and implement adoption of standards that ensured operational and programmatic performance meeting applicable standards of practice for random drug testing instrument including the CLIA (Clinical Laboratory Improvement Amendments) waiver. The findings are:

Review on 11/17/22 of the facility's documents revealed:
-There was no evidence of a CLIA waiver.

Review on 11/17/22 of Former Client #2's record revealed:
-Admission date of 7/11/22.
-Discharge date of 9/13/22.
-Diagnoses of Opioid Dependence, Uncomplicated; Cannabis Dependence, Uncomplicated; Cocaine Dependence, Uncomplicated.
-She received a drug test on 9/12/22.

Review on 11/17/22 of Former Client #3's record revealed:
-Admission date of 4/4/22.
-Discharge date of 11/11/22.
-Diagnosis of Alcohol Dependence, Uncomplicated.
-She received a drug test on the following dates: 6/13/22 and 9/12/22.

Interview on 11/17/22 with the Director revealed:
-Facility staff performed random drug tests on clients residing at the facility.

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V 105	Continued From page 3 -She was initially unaware that facility needed a CLIA waiver in order to conduct the drug tests, but was recently informed by a colleague. -She would request a CLIA certification. -She acknowledged the facility did not have a CLIA certification.	V 105		
V 108	27G .0202 (F-I) Personnel Requirements 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. (i) The governing body shall develop and implement policies and procedures for identifying, reporting, investigating and controlling infectious and communicable diseases of personnel and	V 108		

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V 108	Continued From page 4 clients. This Rule is not met as evidenced by: Based on record reviews and interview, the facility failed to ensure staff had training in Cardiopulmonary Resuscitation and First Aid for two of two audited staff audited (the Director and). The findings are: Review on 11/17/22 of the Director's personal file revealed: -There was a certificate of Cardiopulmonary Resuscitation and First Aid training from eCPRcertification.com. -There was no documentation of Cardiopulmonary Resuscitation and First Aid in person training on file for the Director. Review on 11/17/22 of the House Manager's personal file revealed: -There was a certificate of Cardiopulmonary Resuscitation and First Aid training from eCPRcertification.com. -There was no documentation of Cardiopulmonary Resuscitation and First Aid in person training on file for the Director. Interview on 1/22/19 with the Facility Director revealed: -She had completed her Cardiopulmonary Resuscitation and First Aid training online. -She was not aware that online Cardiopulmonary Resuscitation and First Aid training was not accepted by State regulations. -She had completed the training online because it	V 108		

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V 108	Continued From page 5 had been cited during annual survey on October of 2021. -She acknowledged that the facility failed to ensure staff had training in Cardiopulmonary Resuscitation and First Aid for her and the House Manager. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 108		
V 111	27G .0205 (A-B) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (a) An assessment shall be completed for a client, according to governing body policy, prior to the delivery of services, and shall include, but not be limited to: (1) the client's presenting problem; (2) the client's needs and strengths; (3) a provisional or admitting diagnosis with an established diagnosis determined within 30 days of admission, except that a client admitted to a detoxification or other 24-hour medical program shall have an established diagnosis upon admission; (4) a pertinent social, family, and medical history; and (5) evaluations or assessments, such as psychiatric, substance abuse, medical, and vocational, as appropriate to the client's needs. (b) When services are provided prior to the establishment and implementation of the treatment/habilitation or service plan, hereafter referred to as the "plan," strategies to address the client's presenting problem shall be documented.	V 111		

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V 111	Continued From page 6	V 111		

This Rule is not met as evidenced by:
Based on record review and interview, the facility failed to ensure that an assessment was completed prior to the delivery of services affecting one of three audited clients (#1). The findings are:

Review on 11/17/22 of client #1's record revealed:
-Admission date of 11/14/22.
-Diagnoses of Alcohol Use Disorder, Severe; Cannabis Use Disorder, Severe; Unspecified Mood Disorder. Osteoarthritis in hip (Diagnoses are from old chart from when client was in program in 2019.)
-There was no evidence of an admission assessment completed for client #1 prior to the delivery of services.

Interview 11/17/22 with the Director revealed:
-Client #1 was a former client.
-Client #1 was recently released from jail and had begged her to let her return to the program.
-She was aware that some paperwork was still missing from client #1.
-She was still in the process of gathering the needed information.
-She confirmed that the admission assessment for client #1 was not inside her file.

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V 114	Continued From page 7	V 114		
V 114	27G .0207 Emergency Plans and Supplies 10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES (a) A written fire plan for each facility and area-wide disaster plan shall be developed and shall be approved by the appropriate local authority. (b) The plan shall be made available to all staff and evacuation procedures and routes shall be posted in the facility. (c) Fire and disaster drills in a 24-hour facility shall be held at least quarterly and shall be repeated for each shift. Drills shall be conducted under conditions that simulate fire emergencies. (d) Each facility shall have basic first aid supplies accessible for use. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to conduct fire and disaster drills under conditions that simulate emergencies at least quarterly and repeated for each shift. The findings are: Records review on 11/17/22 of the facility's fire drill log for the last 12 months revealed: -8/3/33- 3rd shift. -7/1/22- 2nd shift. -6/5/22- 2nd shift. -5/9/22- 3rd shift. -4/6/22- 1st shift. -3/9/22- 2nd shift. -2/11/22- 2nd shift. -1/15/22- 2nd shift. -12/1/21- 1st shift.	V 114		

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V 114	Continued From page 8 -There were no fire drills conducted on 3rd shift for the first quarter of 2022. -There were no fire drills conducted on 1st shift for the third quarter of 2022. Records review on 11/17/22 of the facility's disaster drill log for the last 12 months revealed: -8/20/22- 2nd shift. -7/12/22- 2nd shift. -6/10/22- 1st shift. -5/10/22- 2nd shift. -4/16/22- 2nd shift. -3/27/22- 3rd shift. -2/20/22- 1st shift. -1/25/22- 3rd shift. -12/7/21- 2nd shift. -There were no disaster drills conducted on 2nd shift for the first quarter of 2022. -There were no disaster drills conducted on 3rd shift for the second quarter of 2022. -There were no disaster drills conducted on 1st and 3rd shift for the third quarter of 2022. Interview on 11/17/22 with the Director revealed: -Facility operated mainly under one shift. -Staff would come in Wednesdays and stay until Sunday and then be relived by the next staff. -She was unaware that fire drills were following a schedule of three different shifts. -Staff acknowledged not following a set schedule. -She acknowledges that fire and disaster drills were not covered for all shifts for some of quarters. -She confirmed the facility failed to conduct a fire and disaster drill under conditions that simulate emergencies for each shift and for each quarter. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 114		

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V 536	Continued From page 9	V 536		
V 536	27E .0107 Client Rights - Training on Alt to Rest. Int. 10A NCAC 27E .0107 TRAINING ON ALTERNATIVES TO RESTRICTIVE INTERVENTIONS (a) Facilities shall implement policies and practices that emphasize the use of alternatives to restrictive interventions. (b) Prior to providing services to people with disabilities, staff including service providers, employees, students or volunteers, shall demonstrate competence by successfully completing training in communication skills and other strategies for creating an environment in which the likelihood of imminent danger of abuse or injury to a person with disabilities or others or property damage is prevented. (c) Provider agencies shall establish training based on state competencies, monitor for internal compliance and demonstrate they acted on data gathered. (d) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (e) Formal refresher training must be completed by each service provider periodically (minimum annually). (f) Content of the training that the service provider wishes to employ must be approved by the Division of MH/DD/SAS pursuant to Paragraph (g) of this Rule. (g) Staff shall demonstrate competence in the following core areas: (1) knowledge and understanding of the people being served;	V 536		

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V 536	Continued From page 10 (2) recognizing and interpreting human behavior; (3) recognizing the effect of internal and external stressors that may affect people with disabilities; (4) strategies for building positive relationships with persons with disabilities; (5) recognizing cultural, environmental and organizational factors that may affect people with disabilities; (6) recognizing the importance of and assisting in the person's involvement in making decisions about their life; (7) skills in assessing individual risk for escalating behavior; (8) communication strategies for defusing and de-escalating potentially dangerous behavior; and (9) positive behavioral supports (providing means for people with disabilities to choose activities which directly oppose or replace behaviors which are unsafe). (h) Service providers shall maintain documentation of initial and refresher training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcomes (pass/fail); (B) when and where they attended; and (C) instructor's name; (2) The Division of MH/DD/SAS may review/request this documentation at any time. (i) Instructor Qualifications and Training Requirements: (1) Trainers shall demonstrate competence by scoring 100% on testing in a training program aimed at preventing, reducing and eliminating the need for restrictive interventions. (2) Trainers shall demonstrate competence	V 536		

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V 536	Continued From page 11	V 536		

by scoring a passing grade on testing in an instructor training program.
(3) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course.
(4) The content of the instructor training the service provider plans to employ shall be approved by the Division of MH/DD/SAS pursuant to Subparagraph (i)(5) of this Rule.
(5) Acceptable instructor training programs shall include but are not limited to presentation of:
(A) understanding the adult learner;
(B) methods for teaching content of the course;
(C) methods for evaluating trainee performance; and
(D) documentation procedures.
(6) Trainers shall have coached experience teaching a training program aimed at preventing, reducing and eliminating the need for restrictive interventions at least one time, with positive review by the coach.
(7) Trainers shall teach a training program aimed at preventing, reducing and eliminating the need for restrictive interventions at least once annually.
(8) Trainers shall complete a refresher instructor training at least every two years.
(j) Service providers shall maintain documentation of initial and refresher instructor training for at least three years.
(1) Documentation shall include:
(A) who participated in the training and the outcomes (pass/fail);
(B) when and where attended; and
(C) instructor's name.

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V 536	Continued From page 12 (2) The Division of MH/DD/SAS may request and review this documentation any time. (k) Qualifications of Coaches: (1) Coaches shall meet all preparation requirements as a trainer. (2) Coaches shall teach at least three times the course which is being coached. (3) Coaches shall demonstrate competence by completion of coaching or train-the-trainer instruction. (l) Documentation shall be the same preparation as for trainers. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure two of two audited staff (the Director and the House Manager) had current training in the use of alternatives to restrictive interventions. The findings are: Review on 11/17/22 of the Director's personnel file revealed:: -Hire date of 2/7/05. -She was hired as the Director -Last documented training on Alternatives to Restrictive Intervention expired on 7/10/19. -There was no updated documentation of training on alternatives to restrictive intervention. Review on 11/17/22 of the House Manager's personal file revealed: -Hire date of 5/7/13. -She was hired as the House Manager.	V 536		

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V 536	Continued From page 13 -Last documented training on Alternatives to Restrictive Intervention expired on 7/10/19. -There was no updated documentation of training on alternatives to restrictive intervention. Interview on 11/17/22 with the Director revealed: -Facility only used alternatives to restrictive intervention. -She was not aware that the training needed to be updated every year. -The group home used the North Carolina Intervention (NCI) as it's curriculum. -She confirmed she did not have updated documentation of training on alternatives to restrictive intervention.	V 536		
V 736	27G .0303(c) Facility and Grounds Maintenance 10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS (c) Each facility and its grounds shall be maintained in a safe, clean, attractive and orderly manner and shall be kept free from offensive odor. This Rule is not met as evidenced by: Based on observation and interview, the facility failed to ensure facility grounds were maintained in a clean, safe and attractive manner. The findings are: Observation on 11/17/22 at 11:15 a.m. of the Basement revealed: -There were 15 to 20 flattened cardboard boxes laid on the floor at the bottom of steps and	V 736		

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THE BETHANY HOUSE, INC	240 EAST VERMONT AVENUE SOUTHERN PINES, NC 28387

(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 736	Continued From page 14 against the wall. Observation on 11/3/22 at 11:20 a.m. of Bedroom #1 revealed: -There was a hand towel loosely covering the fan on the ceiling. -The ceiling fan was dusty. -Excessive short strings of dust were hanging from the ceiling. Observation on 11/3/22 at 11:25 a.m. of Bedroom #2 revealed: -Fan in ceiling and ceiling were excessively dusty. Observation on 11/3/22 at 11:30 a.m. of Bedroom #3 revealed: -There were two ceiling fans which were excessively dusty as well as the ceiling. Observation on 11/3/22 at 11:35 a.m. of the Upstairs Full Bathroom revealed: -The toilet lid was not attached to the toilet and was seating on the floor against wall. -The vinyl cushioned toilet seat was ripped/cracked on both sides, rips/cracks were about 3 ½ inches in length. -There were two light bulbs out of three missing from light fixture over sink. -The fan in ceiling was rusty.	V 736		