STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0411196	A. BUILDING: _____ B. WING _____	03/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEAUTIFUL BEGINNINGS	3205 STONYPOINTE DRIVE GREENSBORO, NC 27406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 000	INITIAL COMMENTS An annual and complaint survey was completed on March 9, 2023. The complaint was unsubstantiated (Intake #NC00199016). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600F Supervised Living for 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 132	G.S. 131E-256(G) HCPR-Notification, Allegations, & Protection G.S. §131E-256 HEALTH CARE PERSONNEL REGISTRY (g) Health care facilities shall ensure that the Department is notified of all allegations against health care personnel, including injuries of unknown source, which appear to be related to any act listed in subdivision (a)(1) of this section. (which includes: a. Neglect or abuse of a resident in a healthcare facility or a person to whom home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided. b. Misappropriation of the property of a resident in a health care facility, as defined in subsection (b) of this section including places where home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided. c. Misappropriation of the property of a healthcare facility. d. Diversion of drugs belonging to a health care facility or to a patient or client. e. Fraud against a health care facility or against	V 132		

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V 132	Continued From page 1 a patient or client for whom the employee is providing services). Facilities must have evidence that all alleged acts are investigated and must make every effort to protect residents from harm while the investigation is in progress. The results of all investigations must be reported to the Department within five working days of the initial notification to the Department. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure the Department (HCPR) was notified of allegations against facility staff, provide evidence that the allegation was investigated, and report the finding of the investigation to the Department within five working days of making the initial report affecting 1 of 3 clients (client #1). The findings are: Review on 3/7/23 of client #1's record revealed: -An admission date of 10/6/22 -Diagnosis of Mild Intellectual Disability, Autism Spectrum Disorder, Disruptive Mood Dysregulation Disorder, Eczema and Asthma Review on 3/7/23 of the facility's incident report	V 132		

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V 132	Continued From page 2 revealed: -A handwritten report dated 2/22/23 at 11pm and written by the Alternative to Family Living Provider/Qualified Professional/Chief Executive Officer (the AFL Provider/QP/CEO) -"Staff asked [client #1] for his phone because it was past his bedtime. He was keeping everybody up in the home. He got extremely aggressive towards staff and residents in the home. He started hitting staff's door and bathroom door. Yelling at staff and others in the home. Staff believes [client #1] injured himself during the incident. -Describe the cause of the incident [client #1] refused to go to bed. Also didn't want to put his phone up." -Describe how this incident may be prevented: [Client #1] needs to follow a schedule set by himself and staff. [Client #1] needs to learn to talk out his problems when upset." Review on 3/7/23 of the facility's Incident Report revealed: -No internal investigation was conducted to investigate this allegation -No documentation the HCPR was notified of the allegation Review on 3/7/23 of the North Carolina Incident Response Improvement System (IRIS) revealed: -No level III incident report was submitted when the AFL Provider/QP/CEO became aware of the allegation Observations and interview on 3/7/23 with client #1 at 1:54pm revealed -Left arm has a soft cast on it and a sling around his neck -Was asked how he injured his hand -"I may have hit a door or broke a table with my	V 132		

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V 132	Continued From page 3 left hand ... I got into an argument with my mom. I went downstairs and then went upstairs and smashed the door to his (AFL Provider/QP/CEO) bedroom ...he did not break my arm. He did not break my arm. I promise ..." Further interview on 3/7/23 with client #1 revealed: " ...The truth is [the AFL Provider/QP/CEO] is the one that broke my arm. I banged on his door. I was afraid he would take my phone away ...I tried to tell my mom he broke my arm. I promised I would not say anything to you about what happened. I am over it ..." Interview on 3/8/23 with client #1 revealed: -Was asked how his arm was, client #1 stated "I did it to myself. I hit the bedroom door, with my arm. It's all good. I am sorry I told you a lie ...I told you he did it so I could go home." Interview on 3/8/23 with the AFL Provider/QP/CEO revealed: -Had completed the facility's handwritten incident report -Had not conducted an internal investigation in written form -Did not submit a 72-hour report to the HCPR -Would meet with the Qualified Professional Consultant to start an internal investigation into the allegation of physical abuse -Would immediately notify the HCPR of client #1's allegation	V 132		
V 366	27G .0603 Incident Response Requirments 10A NCAC 27G .0603 INCIDENT RESPONSE REQUIREMENTS FOR CATEGORY A AND B PROVIDERS	V 366		

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V 366	Continued From page 4 (a) Category A and B providers shall develop and implement written policies governing their response to level I, II or III incidents. The policies shall require the provider to respond by: (1) attending to the health and safety needs of individuals involved in the incident; (2) determining the cause of the incident; (3) developing and implementing corrective measures according to provider specified timeframes not to exceed 45 days; (4) developing and implementing measures to prevent similar incidents according to provider specified timeframes not to exceed 45 days; (5) assigning person(s) to be responsible for implementation of the corrections and preventive measures; (6) adhering to confidentiality requirements set forth in G.S. 75, Article 2A, 10A NCAC 26B, 42 CFR Parts 2 and 3 and 45 CFR Parts 160 and 164; and (7) maintaining documentation regarding Subparagraphs (a)(1) through (a)(6) of this Rule. (b) In addition to the requirements set forth in Paragraph (a) of this Rule, ICF/MR providers shall address incidents as required by the federal regulations in 42 CFR Part 483 Subpart I. (c) In addition to the requirements set forth in Paragraph (a) of this Rule, Category A and B providers, excluding ICF/MR providers, shall develop and implement written policies governing their response to a level III incident that occurs while the provider is delivering a billable service or while the client is on the provider's premises. The policies shall require the provider to respond by: (1) immediately securing the client record by: (A) obtaining the client record; (B) making a photocopy;	V 366		

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V 366	Continued From page 5 (C) certifying the copy's completeness; and (D) transferring the copy to an internal review team; (2) convening a meeting of an internal review team within 24 hours of the incident. The internal review team shall consist of individuals who were not involved in the incident and who were not responsible for the client's direct care or with direct professional oversight of the client's services at the time of the incident. The internal review team shall complete all of the activities as follows: (A) review the copy of the client record to determine the facts and causes of the incident and make recommendations for minimizing the occurrence of future incidents; (B) gather other information needed; (C) issue written preliminary findings of fact within five working days of the incident. The preliminary findings of fact shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different; and (D) issue a final written report signed by the owner within three months of the incident. The final report shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different. The final written report shall address the issues identified by the internal review team, shall include all public documents pertinent to the incident, and shall make recommendations for minimizing the occurrence of future incidents. If all documents needed for the report are not available within three months of the incident, the LME may give the provider an extension of up to three months to submit the final report; and (3) immediately notifying the following: (A) the LME responsible for the catchment	V 366		

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V 366	Continued From page 6 area where the services are provided pursuant to Rule .0604; (B) the LME where the client resides, if different; (C) the provider agency with responsibility for maintaining and updating the client's treatment plan, if different from the reporting provider; (D) the Department; (E) the client's legal guardian, as applicable; and (F) any other authorities required by law. This Rule is not met as evidenced by: Based on record reviews and interview, the facility failed to conduct an internal review within 24 hours of the incident. The findings are: Review on 3/7/23 of the AFL Provider/Qualified Professional/Chief Executive Officer (the AFL Provider/QP/CEO)'s record revealed: -A hire date of 2/3/20 -A job description of CEO -Education that met the requirements of a QP Review on 3/7/23 of client #1's record revealed: -An admission date of 10/6/22 -Diagnosis of Mild Intellectual Disability, Autism Spectrum Disorder, Disruptive Mood Dysregulation Disorder, Eczema and Asthma Interview on 3/7/23 with the AFL Provider/QP/CEO revealed: -Was made aware client #1 had made the	V 366		

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V 366	Continued From page 7 allegation against him after speaking with client #1's legal guardian -Client #1 had alleged he was physically abused which resulted in a fractured elbow. -Denied the allegation occurred -Had not conducted an internal investigation into client #1's allegation against him -Was not suspended pending the results of the investigation	V 366		
V 367	27G .0604 Incident Reporting Requirements 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall report all level II incidents, except deaths, that occur during the provision of billable services or while the consumer is on the providers premises or level III incidents and level II deaths involving the clients to whom the provider rendered any service within 90 days prior to the incident to the LME responsible for the catchment area where services are provided within 72 hours of becoming aware of the incident. The report shall be submitted on a form provided by the Secretary. The report may be submitted via mail, in person, facsimile or encrypted electronic means. The report shall include the following information: (1) reporting provider contact and identification information; (2) client identification information; (3) type of incident; (4) description of incident; (5) status of the effort to determine the cause of the incident; and (6) other individuals or authorities notified or responding.	V 367		

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V 367	Continued From page 8 (b) Category A and B providers shall explain any missing or incomplete information. The provider shall submit an updated report to all required report recipients by the end of the next business day whenever: (1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or (2) the provider obtains information required on the incident form that was previously unavailable. (c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including: (1) hospital records including confidential information; (2) reports by other authorities; and (3) the provider's response to the incident. (d) Category A and B providers shall send a copy of all level III incident reports to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of becoming aware of the incident. Category A providers shall send a copy of all level III incidents involving a client death to the Division of Health Service Regulation within 72 hours of becoming aware of the incident. In cases of client death within seven days of use of seclusion or restraint, the provider shall report the death immediately, as required by 10A NCAC 26C .0300 and 10A NCAC 27E .0104(e)(18). (e) Category A and B providers shall send a report quarterly to the LME responsible for the catchment area where services are provided. The report shall be submitted on a form provided by the Secretary via electronic means and shall include summary information as follows: (1) medication errors that do not meet the definition of a level II or level III incident;	V 367		

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V 367	Continued From page 9 (2) restrictive interventions that do not meet the definition of a level II or level III incident; (3) searches of a client or his living area; (4) seizures of client property or property in the possession of a client; (5) the total number of level II and level III incidents that occurred; and (6) a statement indicating that there have been no reportable incidents whenever no incidents have occurred during the quarter that meet any of the criteria as set forth in Paragraphs (a) and (d) of this Rule and Subparagraphs (1) through (4) of this Paragraph. This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to submit level II and level III incident reports to the Local Management Entity (LME) within 72 hours as required. The findings are Finding #1 Review on 3/7/23 of the 911 print out to the facility's address revealed: -10/3/22 at 9:34pm, "Mental Subject/Commit (commitment): a mental health member needing to get evaluated, reportedly has a history of violence. [Client #2's name], transported. -10/15/22 at 8:13pm, Threatening Suicide. Argument with roommate. Subject plans suicide. Any way possible. Name [client #2's name]. Someone with caller. Next door neighbor. Subj (Subject) suicidal because too much is going on. Transport. I spoke with [client #2] who stated he	V 367		

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V 367	Continued From page 10 had an argument with someone at [the facility's name] and he wants to harm himself ....transported him to [a behavioral health center]. He lives with [the AFL Provider]. Review on 3/7/23 of the Incident Response Improvement System (IRIS) revealed: -No level II incident reports had been submitted for the incidents on 10/3/22 and 10/15/22 Review on 3/7/23 of the facility's incident reports revealed: -No level II incident reports had been completed Interview on 3/7/23 with the Alternative to Family Living Provider/Qualified Professional/Chief Executive Officer (AFL Provider/QP/CEO)) revealed: -Was not aware he was required to submit level II incident reports when the police came out to the facility's address -Would contact the Qualified Professional Consultant to schedule training Finding #2 Review on 3/7/23 of the Incident Response Improvement System (IRIS) revealed: -No level III incident report was submitted into IRIS Review on 3/7/23 of the facility's incident reports revealed: -No level III incident report had been completed Interview on 3/7/23 with the AFL Provider/QP/CEO revealed: -Was made aware client #1 had made the allegation against him after speaking with client #1's legal guardian -Client #1 had alleged he was physically abused	V 367		

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V 367	Continued From page 11 which resulted in a fractured elbow. -Denied the allegation occurred -Had not submitted a level III incident report into the IRIS system -Was not aware he was required to submit a level III incident report for an allegation of abuse -Would schedule training with the Qualified Professional Consultant	V 367		
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	V 536		

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V 536	Continued From page 12 annually). (f) Content of the training that the service provider wishes to employ must be approved by the Division of MH/DD/SAS pursuant to Paragraph (g) of this Rule. (g) Staff shall demonstrate competence in the following core areas: (1) knowledge and understanding of the people being served; (2) recognizing and interpreting human behavior; (3) recognizing the effect of internal and external stressors that may affect people with disabilities; (4) strategies for building positive relationships with persons with disabilities; (5) recognizing cultural, environmental and organizational factors that may affect people with disabilities; (6) recognizing the importance of and assisting in the person's involvement in making decisions about their life; (7) skills in assessing individual risk for escalating behavior; (8) communication strategies for defusing and de-escalating potentially dangerous behavior; and (9) positive behavioral supports (providing means for people with disabilities to choose activities which directly oppose or replace 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;	V 536		

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V 536	Continued From page 13 (2) The Division of MH/DD/SAS may review/request this documentation at any time. (i) Instructor Qualifications and Training Requirements: (1) Trainers shall demonstrate competence by scoring 100% on testing in a training program aimed at preventing, reducing and eliminating the need for restrictive interventions. (2) Trainers shall demonstrate competence by scoring a passing grade on testing in an instructor training program. (3) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (4) The content of the instructor training the service provider plans to employ shall be approved by the Division of MH/DD/SAS pursuant to Subparagraph (i)(5) of this Rule. (5) Acceptable instructor training programs shall include but are not limited to presentation of: (A) understanding the adult learner; (B) methods for teaching content of the course; (C) methods for evaluating trainee performance; and (D) documentation procedures. (6) Trainers shall have coached experience 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	V 536		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 536	Continued From page 14 instructor training at least every two years. (j) Service providers shall maintain documentation of initial and refresher instructor training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcomes (pass/fail); (B) when and where attended; and (C) instructor's name. (2) The Division of MH/DD/SAS may request and review this documentation any time. (k) Qualifications of Coaches: (1) Coaches shall meet all preparation requirements as a trainer. (2) Coaches shall teach at least three times the course which is being coached. (3) Coaches shall demonstrate competence by completion of coaching or train-the-trainer instruction. (l) Documentation shall be the same preparation as for trainers. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure 1 of 1 staff (the Alternative to Family Living Provider/Qualified Professional/Chief Executive Officer (the AFL Provider/QP/CEO)) had completed annual training in alternatives to restrictive interventions. The findings are: Review on 3/7/23 of the AFL Provider/QP/CEO's record revealed:	V 536		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0411196	A. BUILDING: _____ B. WING _____	03/09/2023

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V 536	Continued From page 15 -A hire date of 2/3/20 -A job description of CEO -Education that met the requirements of a QP -A training certificate for National Crisis Intervention Plus that expired on 11/18/22 Interview on 3/8/23 with the AFL Provider/QP/CEO revealed: -Thought his training on alternatives to restrictive interventions was current -Would schedule the training as soon as possible	V 536		
V 537	27E .0108 Client Rights - Training in Sec Rest & ITO 10A NCAC 27E .0108 TRAINING IN SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT (a) Seclusion, physical restraint and isolation time-out may be employed only by staff who have been trained and have demonstrated competence in the proper use of and alternatives to these procedures. Facilities shall ensure that staff authorized to employ and terminate these procedures are retrained and have demonstrated competence at least annually. (b) Prior to providing direct care to people with disabilities whose treatment/habilitation plan includes restrictive interventions, staff including service providers, employees, students or volunteers shall complete training in the use of seclusion, physical restraint and isolation time-out and shall not use these interventions until the training is completed and competence is demonstrated. (c) A pre-requisite for taking this training is demonstrating competence by completion of training in preventing, reducing and eliminating the need for restrictive interventions.	V 537		

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V 537	Continued From page 16 (d) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (e) Formal refresher training must be completed by each service provider periodically (minimum annually). (f) Content of the training that the service provider plans to employ must be approved by the Division of MH/DD/SAS pursuant to Paragraph (g) of this Rule. (g) Acceptable training programs shall include, but are not limited to, presentation of: (1) refresher information on alternatives to the use of restrictive interventions; (2) guidelines on when to intervene (understanding imminent danger to self and others); (3) emphasis on safety and respect for the rights and dignity of all persons involved (using concepts of least restrictive interventions and incremental steps in an intervention); (4) strategies for the safe implementation of restrictive interventions; (5) the use of emergency safety interventions which include continuous assessment and monitoring of the physical and psychological well-being of the client and the safe use of restraint throughout the duration of the restrictive intervention; (6) prohibited procedures; (7) debriefing strategies, including their importance and purpose; and (8) documentation methods/procedures. (h) Service providers shall maintain documentation of initial and refresher training for at least three years.	V 537		

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V 537	Continued From page 17 (1) Documentation shall include: (A) who participated in the training and the outcomes (pass/fail); (B) when and where they attended; and (C) instructor's name. (2) The Division of MH/DD/SAS may review/request this documentation at any time. (i) Instructor Qualification and Training Requirements: (1) Trainers shall demonstrate competence by scoring 100% on testing in a training program aimed at preventing, reducing and eliminating the need for restrictive interventions. (2) Trainers shall demonstrate competence by scoring 100% on testing in a training program teaching the use of seclusion, physical restraint and isolation time-out. (3) Trainers shall demonstrate competence by scoring a passing grade on testing in an instructor training program. (4) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (5) The content of the instructor training the service provider plans to employ shall be approved by the Division of MH/DD/SAS pursuant to Subparagraph (j)(6) of this Rule. (6) Acceptable instructor training programs shall include, but not be limited to, presentation of: (A) understanding the adult learner; (B) methods for teaching content of the course; (C) evaluation of trainee performance; and (D) documentation procedures. (7) Trainers shall be retrained at least	V 537		

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V 537	Continued From page 18 annually and demonstrate competence in the use of seclusion, physical restraint and isolation time-out, as specified in Paragraph (a) of this Rule. (8) Trainers shall be currently trained in CPR. (9) Trainers shall have coached experience in teaching the use of restrictive interventions at least two times with a positive review by the coach. (10) Trainers shall teach a program on the use of restrictive interventions at least once annually. (11) Trainers shall complete a refresher instructor training at least every two years. (k) Service providers shall maintain documentation of initial and refresher instructor training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcome (pass/fail); (B) when and where they attended; and (C) instructor's name. (2) The Division of MH/DD/SAS may review/request this documentation at any time. (l) Qualifications of Coaches: (1) Coaches shall meet all preparation requirements as a trainer. (2) Coaches shall teach at least three times, the course which is being coached. (3) Coaches shall demonstrate competence by completion of coaching or train-the-trainer instruction. (m) Documentation shall be the same preparation as for trainers.	V 537		

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V 537	Continued From page 19 This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure 1 of 1 staff (the Alternative to Family Living Provider/Qualified Professional/Chief Executive Officer (AFL Provider/QP/CEO)) had completed annual training in seclusion, physical restraint, and isolation/time out. The findings are: Review on 3/7/23 of the AFL Provider/QP/CEO's record revealed: -A hire date of 2/3/20 -A job description of CEO -Education that met the requirements of a QP -A training certificate for National Crisis Intervention Plus that expired on 11/18/22 Interview on 3/8/23 with the AFL Provider/QP/CEO revealed: -The facility used seclusion, physical restraint and isolation/time-out -Thought his training was current -Would schedule the training as soon as possible	V 537		