	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	CONSTRUCTION	(X3) DATE S COMPLE	
ANDILAN	or connection	IDENTIFICATION NOMBER.	A. BUILDING: _			
		MHL045-067	B. WING		03/0	8/2023
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
HILLPARK	GROUP HOME	175 ELSON				
	OLIMAN DV OT		ONVILLE, NC			
(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 CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
V 000	INITIAL COMMENTS		V 000			
	completed on March	, and follow up survey was 8, 2023. The complaint was ‡ 198856). Deficiencies				
	category: 10A NCAC	d for the following service 27G .5600C Supervised Developmental Disabilities.				
	<u>-</u>	d for 6 and currently has a vey sample consisted of ents.				
V 114	27G .0207 Emergence	y Plans and Supplies	V 114			
	AND SUPPLIES (a) A written fire plan area-wide disaster plashall be approved by authority. (b) The plan shall be and evacuation proceposted in the facility. (c) Fire and disaster coshall be held at least repeated for each shi under conditions that	an shall be developed and				
	facility failed to condu	as evidenced by: ew and interviews, the act fire and disaster drills on arterly. The findings are:				

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

	FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:		(X3) DATE COMF	SURVEY PLETED
						R
		MHL045-067	B. WING	·	03	/08/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	E, ZIP CODE		
HILLPAR	GROUP HOME		ON AVENUE RSONVILLE, NC 2	8739		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF (CORRECTION	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIVE CROSS-REFERENCED TO THE DEFICIENCY	HE APPROPRIATE	COMPLETE DATE
V 114	Continued From page	e 1	V 114			
	drill log revealed: -No documentation o following shifts and q - July - Septemb					
	following shifts and q - July - Septemb	of disaster drills during the uarters: er 2022: 2nd shift; ember 2022: 2nd shift				
		vith Client #1 revealed: n fire drills at the facility.				
	revealed: -all of the staff were r fire and disaster drills	the facility that reminded re to be completed;				
	Professional revealed -he could not find the drills;	paperwork for the missing re around the time when a				
	This deficiency const and must be correcte	itutes a re-cited deficiency d within 30 days.				
V 131	G.S. 131E-256 (D2) l Verification	HCPR - Prior Employment	V 131			
	REGISTRY	ALTH CARE PERSONNEL alth care personnel into a				

Division of Health Service Regulation

STATE FORM 6899 0OWS11 If continuation sheet 2 of 15

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
		MHI 045 067	B. WING		R 03/08/2023
	20/4050 65 51/55	MHL045-067			03/06/2023
NAME OF PI	ROVIDER OR SUPPLIER		RESS, CITY, STA	ILE, ∠IP CODE	
HILLPARK	GROUP HOME	175 ELSON HENDERSO	NVILLE, NC	28739	
()(1) ID	SLIMMARY ST	ATEMENT OF DEFICIENCIES	· ·	PROVIDER'S PLAN OF CORRECTION	1 (V5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE
V 131	Continued From page	e 2	V 131		
	health care facility or health care facility sh Personnel Registry a	service, every employer at a all access the Health Care nd shall note each incident opriate business files.			
	failed to access the H	ew and interview, the facility lealth Care Personnel r to hiring 1 of 3 audited staff			
	revealed: -Hire Date: 2/16/23; -Position: Direct Sup -Further review revea	iled that HCPR was vith the incorrect social			
	-he accessed HCPR security number for S showed it to surveyor	d: leave in January 2023; with the correct social staff #2 on this date and			
	This deficiency consti and must be correcte	itutes a re-cited deficiency d within 30 days.			
V 132	G.S. 131E-256(G) HO Allegations, & Protect		V 132		
	G.S. §131E-256 HEA	LTH CARE PERSONNEL			

Division of Health Service Regulation

STATE FORM 6899 0OWS11 If continuation sheet 3 of 15

PRINTED: 03/16/2023 FORM APPROVED

Division of Health Service Regulation

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S COMPLI	
			D WING		R	
		MHL045-067	B. WING		03/0	08/2023
NAME OF P	ROVIDER OR SUPPLIER		RESS, CITY, STA	TE, ZIP CODE		
HILLPAR	GROUP HOME	175 ELSON HENDERSO	NVILLE, NC	28739		
(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 CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
V 132	Department is notified health care personnel unknown source, which any act listed in subdit (which includes: a. Neglect or abuse facility or a person to as defined by G.S. 13 as defined by G.S. 13 b. Misappropriation of in a health care facility (b) of this section includer services as defined by G.S. 13 b. Misappropriation of in a health care facility (b) of this section includer services as defined by G.S. 13 b. Misappropriation of the services as defined by G.S. 13 b. Mis	es shall ensure that the d of all allegations against l, including injuries of ch appear to be related to vision (a)(1) of this section. of a resident in a healthcare whom home care services of E-136 or hospice services of the property of a resident ly, as defined in subsection uding places where home led by G.S. 131E-136 or lefined by G.S. 131E-201 of the property of a seldent ly as belonging to a health care or client. ealth care facility or against whom the employee is levidence that all alleged and must make every effort om harm while the gress. The results of all le reported to the er working days of the initial	V 132			

Division of Health Service Regulation

STATE FORM 6899 0OWS11 If continuation sheet 4 of 15

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING:	
		MHL045-067	B. WING		R 03/08/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE	,
HII I DARK	GROUP HOME	175 ELS	ON AVENUE		
THEEL AIG			SONVILLE, NC		
(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 CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
V 132	Continued From page	÷ 4	V 132		
	This Rule is not met	as evidenced by: ew and interviews, the			
	facility failed to report	allegations of abuse to the el Registry (HCPR) The			
	Date of Admission: 6 Diagnoses: Mood Diagnoses: Mood Diagnoses	sorder (D/O), Moderate lental D/O (IDD), Cerebral ve Delay, Gastroesophageal D) and Arthrogryposis;			
	Date of Admission: 8 Diagnoses: Personal Mental/Behavioral D/0 Blindness of Right Ey	History of Other O, Cerebral Palsy, Epilepsy, e, Normal Vision of Left ebrospinal Fluid Drainage			
	Review on 3/7/23 of S revealed: Hire Date: 11/2/09; Position: Direct Supp	Staff #1's personnel record			
	Review on 3/7/23 of S revealed: Hire Date: 2/9/22; Position: Direct Supp	Staff #3's personnel record			
	Review on 3/6/23 of t	he North Carolina Incident			

Division of Health Service Regulation

Response Improvement System (IRIS) revealed:

STATE FORM 6899 00WS11 If continuation sheet 5 of 15

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION		SURVEY PLETED
		MHL045-067	B. WING		03	R 5/ 08/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STAT	E, ZIP CODE		
HILLPAR	C GROUP HOME		ON AVENUE SONVILLE, NC 2	8739		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
V 132	-2/21/23, incident tha (Staff #1 and #3) had (Client #2, #3) and th non-ambulatory had be Staff #3 and that her modified so that she as of the incident report. Review on 3/7/23 of the incident of the incident report. Professional dated 2/2-An investigation was found the allegations #3 by Staff #1, and #3/23 Professional revealed the Holincident, "we take it some was not sure why IRIS. Interview on 3/8/23 we revealed:	t alleged two direct care staff verbally abused two clients at Client #2, who is been shut in her room by wheelchair had been could not leave her room. alled that the HCPR section had not been completed. The facility's internal ed by the Qualified (27/23 revealed: a started on 2/21/23 that of abuse of Client #2, and 3 to be unsubstantiated. With the Qualified d: for IRIS reports; CPR section regarding this	V 132			
V 536	27E .0107 Client Rigl Int.	nts - Training on Alt to Rest.	V 536			
	to restrictive intervent (b) Prior to providing	RESTRICTIVE plement policies and size the use of alternatives				

Division of Health Service Regulation

STATE FORM 6899 0OWS11 If continuation sheet 6 of 15

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE HILLPARK GROUP HOME 175 ELSON AVENUE HENDERSONVILLE, NC 28739 (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) V 536 Continued From page 6 employees, students or volunteers, shall	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SU	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 175 ELSON AVENUE HENDERSONVILLE, NC 28739 (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) V 536 Continued From page 6 NHL045-067 STREET ADDRESS, CITY, STATE, ZIP CODE 175 ELSON AVENUE HENDERSONVILLE, NC 28739 (X5) CORRECTION PROVIDER'S PLAN OF CORRECTION (EACH CORRECTION SHOULD BE COMPLETED TO THE APPROPRIATE DATE) V 536 Continued From page 6			A. BUILDING: _		_	
HILLPARK GROUP HOME 175 ELSON AVENUE HENDERSONVILLE, NC 28739 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) V 536 Continued From page 6 175 ELSON AVENUE HENDERSONVILLE, NC 28739 ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE V 536		MHL045-067	B. WING		1	/2023
HENDERSONVILLE, NC 28739 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) V 536 Continued From page 6 V 536 HENDERSONVILLE, NC 28739 ID PROVIDER'S PLAN OF CORRECTION (X5) (EACH CORRECTIVE ACTION SHOULD BE COMPLE' DATE DEFICIENCY)	NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
HENDERSONVILLE, NC 28739 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) V 536 Continued From page 6 V 536		175 ELSO	N AVENUE			
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) V 536 Continued From page 6 PREFIX TAG REGULATORY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) V 536 V 536	HILLPARK GROUP HOME	HENDERS	ONVILLE, NC	28739		
	PREFIX (EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	BE	COMPLETE
employees students or volunteers shall	V 536 Continued From page	le 6	V 536			
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; (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; (6) recognizing cultural, environmental and organizational factors that may affect people with disabilities;	employees, students demonstrate compe completing training in other strategies for or which the likelihood or injury to a person property damage is (c) Provider agencies based on state compliance and demograthered. (d) The training shall include measurable measurable testing in behavior) on those of methods to determine course. (e) Formal refreshed by each service provider wishes to each service provider wishe	s or volunteers, shall tence by successfully in communication skills and creating an environment in of imminent danger of abuse with disabilities or others or prevented. The shall establish training petencies, monitor for internal constrate they acted on data and be competency-based, learning objectives, written and by observation of objectives and measurable are passing or failing the artraining must be completed or training must be completed or training that the service employ must be approved by applySAS pursuant to a Rule. Instrate competence in the service and understanding of the service of internal and at may affect people with for building positive arsons with disabilities; groultural, environmental and	V 536			

Division of Health Service Regulation

STATE FORM 6899 0OWS11 If continuation sheet 7 of 15

TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) V 536 Continued From page 7 assisting in the person's involvement in making decisions about their life; (7) skills in assessing individual risk for	STATEMENT OF DEFICIENCIES (X: AND PLAN OF CORRECTION	(1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SUF COMPLET	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE HILLPARK GROUP HOME 175 ELSON AVENUE HENDERSONVILLE, NC 28739 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) V 536 Continued From page 7 assisting in the person's involvement in making decisions about their life; (7) skills in assessing individual risk for					l R	
HILLPARK GROUP HOME 175 ELSON AVENUE HENDERSONVILLE, NC 28739 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) V 536 Continued From page 7 assisting in the person's involvement in making decisions about their life; (7) skills in assessing individual risk for		MHL045-067	B. WING			2023
HENDERSONVILLE, NC 28739 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) V 536 Continued From page 7 assisting in the person's involvement in making decisions about their life; (7) skills in assessing individual risk for	NAME OF PROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STAT	FE, ZIP CODE		
CACH DEFICIENCY MUST BE PRECEDED BY FULL TAG CONTINUED FROM THE PRESONVILLE, NC 28739 PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG PREFIX TAG PREF		175 ELSOI	N AVENUE			
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) V 536 Continued From page 7 assisting in the person's involvement in making decisions about their life; (7) skills in assessing individual risk for	HILLPARK GROUP HOME	HENDERS	ONVILLE, NC 2	28739		
assisting in the person's involvement in making decisions about their life; (7) skills in assessing individual risk for	PREFIX (EACH DEFICIENCY MU	IUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	D BE	COMPLETE
decisions about their life; (7) skills in assessing individual risk for	V 536 Continued From page 7		V 536			
(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 by scoring a passing grade on testing in an instructor training program. (3) The training shall be competence by accompany and the competence by scoring a passing grade on testing in an instructor training program. (3) The training shall be competence by scoring a passing grade on testing in an instructor training the need for restrictive interventions. (4) The content of the instructor training the service provider plans to employ shall be	assisting in the person's decisions about their life (7) skills in assess escalating behavior; (8) communication and de-escalating potent and (9) positive behavior means for people with diactivities which directly obehaviors which are uns (h) Service providers sh documentation of initial at least three years. (1) Documentation (A) who participate outcomes (pass/fail); (B) when and whe (C) instructor's nail (2) The Division of review/request this docu (i) Instructor Qualification Requirements: (1) Trainers shall oby scoring 100% on testing aimed at preventing, reduced for restrictive intervence (2) Trainers shall oby scoring a passing grainstructor training programinstructor training prog	s involvement in making e; sing individual risk for n strategies for defusing ntially dangerous behavior; vioral supports (providing lisabilities to choose oppose or replace safe). nall maintain and refresher training for n shall include: ed in the training and the ere they attended; and ame; of MH/DD/SAS may umentation at any time. ons and Training demonstrate competence ting in a training program ducing and eliminating the ventions. demonstrate competence ade on testing in an am. hall be ude measurable learning testing (written and by) on those objectives and determine passing or	V 536			

Division of Health Service Regulation

STATE FORM 6899 0OWS11 If continuation sheet 8 of 15

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BUILDING: _		
		MHL045-067	B. WING		R 03/08/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET AF	DDRESS, CITY, STA	TE ZIP CODE	
TO THE OT THE	TO VIDERY ON OUT FEILING				
HILLPARK	GROUP HOME		ON AVENUE	20720	
			SONVILLE, NC		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
V 536	Continued From page	e 8	V 536		
	to Subparagraph (i)(5	i) of this Rule			
		instructor training programs			
		not limited to presentation of:			
		ng the adult learner;			
		r teaching content of the			
	course;				
		r evaluating trainee			
	performance; and				
		ion procedures.			
	(6) Trainers shall have coached experience				
		ogram aimed at preventing, ing the need for restrictive			
	_	one time, with positive			
	review by the coach.	one time, with positive			
	<u> </u>	all teach a training program			
		reducing and eliminating the			
		terventions at least once			
	annually.				
	(8) Trainers sha	all complete a refresher			
	instructor training at le				
	(j) Service providers				
		al and refresher instructor			
	training for at least the	_			
	()	entation shall include:			
	. ,	ated in the training and the			
	outcomes (pass/fail); (B) when and w	vhere attended; and			
	(C) instructor's				
		n of MH/DD/SAS may			
		is documentation any time.			
	(k) Qualifications of 0	•			
	· /	all meet all preparation			
	requirements as a tra				
	` '	all teach at least three times			
	the course which is be	_			
	(-)	all demonstrate			
	competence by comp				
	train-the-trainer instru				
	(I) Documentation sh	all be the same preparation			

Division of Health Service Regulation

STATE FORM 6899 0OWS11 If continuation sheet 9 of 15

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
					R	
		MHL045-067	B. WING		03/08/2023	
NAME OF PE	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
HILLPARK GROUP HOME 175 ELSO			N AVENUE			
		HENDERS	SONVILLE, NC	28739		
(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 CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLET	E
V 536	Continued From page	9	V 536			
	as for trainers.					
	This Rule is not met	-				
		ew and interviews, the e 1 of 3 audited staff, (Staff				
		use of alternatives to				
	restrictive intervention					
	services. The finding	s are:				
	Povious on 2/7/22 of 9	Stoff#2's percepted record				
	revealed:	Staff#2's personnel record				
	-Hire Date: 2/16/23;					
	-Position: Direct Sup					
		f training on alternatives to				
	restrictive intervention	n in tile.				
	Interview on 3/6/23 w	ith Staff #2 revealed:				
		week of employment at the				
	facility;					
	-she provided direct of	are to the clients.				
	Interview on 3/7/23 w	ith the Qualified				
	Professional revealed					
	•	the restrictive intervention				
	class for facility staff;					
	-ne was scheduled to	train Staff #2 next week.				
V 537	27E .0108 Client Right ITO	nts - Training in Sec Rest &	V 537			
	10A NCAC 27E .0108 SECLUSION, PHYSION	TRAINING IN CAL RESTRAINT AND				

Division of Health Service Regulation

STATE FORM 6899 0OWS11 If continuation sheet 10 of 15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE S COMPLE	
		B WINC		R	
L	MHL045-067	B. WING		03/0	8/2023
NAME OF PROVIDER OR SUPPLIER	STREET ADDI	RESS, CITY, STA	TE, ZIP CODE		
HILLPARK GROUP HOME	175 ELSON				
		ONVILLE, NC			
PREFIX (EACH DEFICIENCY I	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
been trained and have competence in the propto to these procedures. F staff authorized to emplor procedures are retrained competence at least and (b) Prior to providing didisabilities whose treatrincludes restrictive interservice providers, emplor volunteers shall complesedusion, physical rest and shall not use these training is completed and demonstrated. (c) A pre-requisite for the demonstrating competed training in preventing, rethe need for restrictive in (d) The training shall be include measurable least measurable testing (write behavior) on those objet methods to determine procurse. (e) Formal refresher training provider plans to emplote the Division of MH/DD/S Paragraph (g) of this Ruring (g) Acceptable training but are not limited to, proceedings and the provided to the provided to the provided the pro	I restraint and isolation yed only by staff who have demonstrated per use of and alternatives facilities shall ensure that loy and terminate these and have demonstrated inually. The care to people with ment/habilitation plan reservations, staff including loyees, students or lete training in the use of traint and isolation time-out enterventions until the end competence is laking this training is lence by completion of reducing and eliminating interventions. The competency-based, arning objectives, litten and by observation of lectives and measurable passing or failing the laining must be completed leter periodically (minimum ling that the service loy must be approved by SAS pursuant to lule. The programs shall include, resentation on alternatives to	V 537			

Division of Health Service Regulation

STATE FORM 6899 0OWS11 If continuation sheet 11 of 15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:	(X3) DATE SURVEY COMPLETED
	MIII 045 007	B. WING	R
	MHL045-067	B. WING	03/08/2023
NAME OF PROVIDER OR SUPPL	ER STREET	DDRESS, CITY, STATE, ZIP CODE	
HILLPARK GROUP HOME		ON AVENUE	
1		SONVILLE, NC 28739	
PREFIX (EACH DE	ARY STATEMENT OF DEFICIENCIES FICIENCY MUST BE PRECEDED BY FULL RY OR LSC IDENTIFYING INFORMATION)	PREFIX (EACH CORRECTIV TAG CROSS-REFERENCE	AN OF CORRECTION (X5) FE ACTION SHOULD BE COMPLETE D TO THE APPROPRIATE DATE ICIENCY)
V 537 Continued Fro	n page 11	V 537	
(2) guide (understanding others); (3) emplifights and digriconcepts of lea incremental str. (4) strate of restrictive in (5) the uninterventions wassessment at psychological use of restrain restrictive inter (6) proh (7) debrimportance and (8) documentation at least three youtcomes (pass (B) when (C) instr. (2) The review/request (i) Instructor (C) Requirements (1) Trair by scoring 100 aimed at preveneed for restric (2) Trair by scoring 100 aimed at preveneed for restric (2) Trair by scoring 100 aimed at preveneed for restric (2) Trair by scoring 100 aimed at preveneed for restric (2) Trair by scoring 100 aimed at preveneed for restric (2) Trair by scoring 100 aimed at preveneed for restric (2) Trair by scoring 100 aimed at preveneed for restric (2) Trair by scoring 100 aimed at preveneed for restric (2) Trair by scoring 100 aimed at preveneed for restric (2) Trair	lines on when to intervene imminent danger to self and asis on safety and respect for the ty of all persons involved (using st restrictive interventions and ps in an intervention); gies for the safe implementation erventions; se of emergency safety hich include continuous d monitoring of the physical and vell-being of the client and the safe throughout the duration of the vention; bited procedures; effing strategies, including their lapurpose; and mentation methods/procedures. viders shall maintain of initial and refresher training for ears. mentation shall include: articipated in the training and the safail); and where they attended; and actor's name. Division of MH/DD/SAS may this documentation at any time. utalification and Training ers shall demonstrate competence of on testing in a training program the interventions. Ers shall demonstrate competence of on testing in a training program e of seclusion, physical restraint	V 337	

Division of Health Service Regulation

STATE FORM 6899 0OWS11 If continuation sheet 12 of 15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			
		MHL045-067	B. WING		R 03/08/2023	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
		175 ELSON				
HILLPAR	GROUP HOME		ONVILLE, NC	28739		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE	
V 537	Continued From page 12		V 537			
V 53/	(3) Trainers shaby scoring a passing instructor training pro (4) The training competency-based, in objectives, measurable observation of behaving measurable methods failing the course. (5) The content service provider plans approved by the Divisito Subparagraph (j)(6) Acceptable shall include, but not of: (A) understandi (B) methods for course; (C) evaluation of the course of seclusion, physical time-out, as specified Rule. (8) Trainers shall include the use of least two times with a coach. (10) Trainers shall use of restrictive internanually. (11) Trainers shall include.	all demonstrate competence grade on testing in an gram. g shall be include measurable learning ble testing (written and by itor) on those objectives and ito determine passing or at of the instructor training the sito employ shall be sion of MH/DD/SAS pursuant itorities of this Rule. Instructor training programs be limited to, presentation in githe adult learner; in teaching content of the conference of trainee performance; and iton procedures. The instructor training at least in Paragraph (a) of this in Paragraph (a) of this in Paragraph (b) of this in Paragraph (c) of this in Paragraph	V 53/			
instructor training at least every two years. (k) Service providers shall maintain documentation of initial and refresher instructor.						

Division of Health Service Regulation

STATE FORM 6899 0OWS11 If continuation sheet 13 of 15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED			
ANDILAN	SI CONNECTION	IDENTIFICATION NOMBER.	A. BUILDING: _		COMILE	-120		
MHL045-067		B. WING		R 03/08/2023				
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE				
HILLPARK GROUP HOME 175 ELSON AVENUE								
	HENDERSONVILLE, NC 28739							
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE		
V 537	(A) who particip outcome (pass/fail); (B) when and v (C) instructor's (2) The Division review/request this do (I) Qualifications of C (1) Coaches shrequirements as a tra (2) Coaches sh times, the course whi	ree years. tion shall include: ated in the training and the where they attended; and name. n of MH/DD/SAS may becomentation at any time. coaches: hall meet all preparation iner. hall teach at least three ch is being coached. hall demonstrate heletion of coaching or liction. hall be the same	V 537					
	facility failed to ensur (Staff #2) had current seclusion, physical re out. The findings are Review on 3/7/23 of Srevealed: -Hire Date: 2/16/23; -Position: Direct Sup-No documentation of seclusion, physical re out.	ew and interviews, the e that 1 of 3 audited staff, training in the use of estraints, and isolation time : Staff#2's personnel record port Professional; f training on the use of estraints, and isolation time						

Division of Health Service Regulation

STATE FORM 6899 0OWS11 If continuation sheet 14 of 15

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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			D 148110			R	
		MHL045-067	B. WING		03	/08/2023	
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STA	TE, ZIP CODE			
HILLPARK GROUP HOME 175 ELSON AVENUE HENDERSONVILLE, NC 28739							
(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 CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE	
V 537	facility; -she had not observed facility; -she provided direct of linterview on 3/7/23 where the professional revealed facility staff were training them; -Staff #2 was a new here.	d any restraints in the care to the clients. ith the Qualified i: ned in holds, but don't use	V 537				

Division of Health Service Regulation

STATE FORM 6899 0OWS11 If continuation sheet 15 of 15