

Division of Health Service Regulation

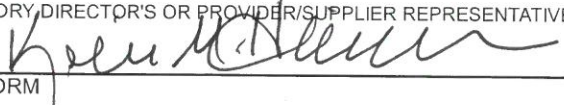
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>mhI007-058</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  R <b>03/10/2023</b>
--	---	---	--

NAME OF PROVIDER OR SUPPLIER  <b>COUNTRY LIVING GUEST HOME #5</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>204 STEWART DRIVE WASHINGTON, NC 27889</b>
---	--

(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	<p><b>INITIAL COMMENTS</b></p> <p>An annual and follow up survey was completed on March 10, 2023. A deficiency was cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities.</p> <p>This facility is licensed for 6 and currently has a census of 6. The survey sample consisted of audits of 3 current clients.</p>	V 000		
V 536	<p><b>27E .0107 Client Rights - Training on Alt to Rest. Int.</b></p> <p>10A NCAC 27E .0107 TRAINING ON ALTERNATIVES TO RESTRICTIVE INTERVENTIONS</p> <p>(a) Facilities shall implement policies and practices that emphasize the use of alternatives to restrictive interventions.</p> <p>(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.</p> <p>(c) Provider agencies shall establish training based on state competencies, monitor for internal compliance and demonstrate they acted on data gathered.</p> <p>(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.</p>	V 536	<p><b>RECEIVED</b></p> <p><b>MAR 28 2023</b></p> <p><b>DHSR-MH Licensure Sect</b></p>	

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



TITLE

*Adman, L. G.*

(X6) DATE

**3/23/23**

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>mhI007-058</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>03/10/2023</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>COUNTRY LIVING GUEST HOME #5</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>204 STEWART DRIVE WASHINGTON, NC 27889</b>
---	--

(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	<p>Continued From page 1</p> <p>(e) Formal refresher training must be completed by each service provider periodically (minimum annually).</p> <p>(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.</p> <p>(g) Staff shall demonstrate competence in the following core areas:</p> <p>(1) knowledge and understanding of the people being served;</p> <p>(2) recognizing and interpreting human behavior;</p> <p>(3) recognizing the effect of internal and external stressors that may affect people with disabilities;</p> <p>(4) strategies for building positive relationships with persons with disabilities;</p> <p>(5) recognizing cultural, environmental and organizational factors that may affect people with disabilities;</p> <p>(6) recognizing the importance of and assisting in the person's involvement in making decisions about their life;</p> <p>(7) skills in assessing individual risk for escalating behavior;</p> <p>(8) communication strategies for defusing and de-escalating potentially dangerous behavior; and</p> <p>(9) positive behavioral supports (providing means for people with disabilities to choose activities which directly oppose or replace behaviors which are unsafe).</p> <p>(h) Service providers shall maintain documentation of initial and refresher training for at least three years.</p> <p>(1) Documentation shall include:</p> <p>(A) who participated in the training and the outcomes (pass/fail);</p>	V 536		
-------	---	-------	--	--

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>mhl007-058</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>03/10/2023</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>COUNTRY LIVING GUEST HOME #5</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>204 STEWART DRIVE WASHINGTON, NC 27889</b>
---	--

(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	<p>Continued From page 2</p> <p>(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 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</p>	V 536		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>mhi007-058</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>03/10/2023</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>COUNTRY LIVING GUEST HOME #5</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>204 STEWART DRIVE</b> <b>WASHINGTON, NC 27889</b>
---	--

(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	<p>Continued From page 3</p> <p>annually.</p> <p>(8) Trainers shall complete a refresher instructor training at least every two years.</p> <p>(j) Service providers shall maintain documentation of initial and refresher instructor training for at least three years.</p> <p>(1) Documentation shall include:</p> <p>(A) who participated in the training and the outcomes (pass/fail);</p> <p>(B) when and where attended; and</p> <p>(C) instructor's name.</p> <p>(2) The Division of MH/DD/SAS may request and review this documentation any time.</p> <p>(k) Qualifications of Coaches:</p> <p>(1) Coaches shall meet all preparation requirements as a trainer.</p> <p>(2) Coaches shall teach at least three times the course which is being coached.</p> <p>(3) Coaches shall demonstrate competence by completion of coaching or train-the-trainer instruction.</p> <p>(l) Documentation shall be the same preparation as for trainers.</p> <p> </p> <p>This Rule is not met as evidenced by: Based on record reviews and interview the facility failed to ensure two of two audited staff (#1 and Qualified Professional (QP)) received annual training updates in alternatives to restrictive interventions. The findings are:</p> <p> </p> <p>Review on 03/10/23 of staff #1 record revealed: - Hire date 12/31/21.</p>	V 536		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>mhi007-058</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>R</b> <b>03/10/2023</b>
NAME OF PROVIDER OR SUPPLIER  <b>COUNTRY LIVING GUEST HOME #5</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>204 STEWART DRIVE</b> <b>WASHINGTON, NC 27889</b>		
(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	<p>Continued From page 4</p> <ul style="list-style-type: none"> <li>- Non-Violent Crisis Intervention (NCI) expired 12/06/22.</li> <li>- No current training in alternatives to restrictive interventions.</li> </ul> <p>Review on 03/10/23 of the QP's record revealed:</p> <ul style="list-style-type: none"> <li>- Hire date 06/04/07.</li> <li>- NCI expired 01/10/23.</li> <li>- No current training in alternatives to restrictive interventions.</li> </ul> <p>Interview on 03/10/23 the Facility Administrator stated:</p> <ul style="list-style-type: none"> <li>- She understood training updates in alternatives to restrictive interventions should be completed annually.</li> <li>- Training updates in alternatives to restrictive interventions had previously been scheduled for the end of this month.</li> </ul>	V 536	<p>NCI + training had already previously been scheduled for March 23rd ? 24<sup>th</sup>. QP and all staff are required to attend this recertification training annually.</p>	<p>3/24/23 3/25/23</p>



NC DEPARTMENT OF  
**HEALTH AND  
HUMAN SERVICES**

ROY COOPER • Governor

KODY H. KINSLEY • Secretary

MARK PAYNE • Director, Division of Health Service Regulation

March 16, 2023

Kellie Hardison, Administrator  
Country Living Guest Home, Inc.  
204 Stewart Drive  
Washington, NC 27889

Re: Annual and Follow Up Survey completed March 10, 2023  
Country Living Guest Home #5, 204 Stewart Drive, Washington, NC 27889  
MHL # 007-058  
E-mail Address: [countrylivinginc@yahoo.com](mailto:countrylivinginc@yahoo.com)

Dear Ms. Hardison:

Thank you for the cooperation and courtesy extended during the annual and follow up survey completed March 10, 2023.

As a result of the follow up survey, it was determined that the deficiency is now in compliance, which is reflected on the enclosed Revisit Report. A deficiency was cited during the survey.

Enclosed you will find all deficiencies cited listed on the Statement of Deficiencies Form. The purpose of the Statement of Deficiencies is to provide you with specific details of the practice that does not comply with state regulations. You must develop one Plan of Correction that addresses each deficiency listed on the State Form, and return it to our office within ten days of receipt of this letter. Below you will find details of the type of deficiencies found, the time frames for compliance plus what to include in the Plan of Correction.

**Type of Deficiencies Found**

- The tag cited is a standard level deficiency.

**Time Frames for Compliance**

- A standard level deficiency must be **corrected** within 60 days from the exit of the survey, which is May 9, 2023.

**What to include in the Plan of Correction**

- Indicate what measures will be put in place to **correct** the deficient area of practice (i.e. changes in policy and procedure, staff training, changes in staffing patterns, etc.).
- Indicate what measures will be put in place to **prevent** the problem from occurring again.
- Indicate **who will monitor** the situation to ensure it will not occur again.
- Indicate **how often** the monitoring will take place.
- Sign and date the bottom of the first page of the State Form.

Make a copy of the Statement of Deficiencies with the Plan of Correction to retain for your records. ***Please do not include confidential information in your plan of correction and please remember never to send confidential information (protected health information) via email.***

**MENTAL HEALTH LICENSURE & CERTIFICATION SECTION**

**NC DEPARTMENT OF HEALTH AND HUMAN SERVICES • DIVISION OF HEALTH SERVICE REGULATION**

LOCATION: 1800 Umstead Drive, Williams Building, Raleigh, NC 27603  
MAILING ADDRESS: 2718 Mail Service Center, Raleigh, NC 27699-2718  
[www.ncdhhs.gov/dhsr](http://www.ncdhhs.gov/dhsr) • TEL: 919-855-3795 • FAX: 919-715-8078

AN EQUAL OPPORTUNITY / AFFIRMATIVE ACTION EMPLOYER

March 16, 2023  
Country Living Guest Home #5  
Country Living Guest Home, Inc.

Send the original completed form to our office at the following address within 10 days of receipt of this letter.

Mental Health Licensure and Certification Section  
NC Division of Health Service Regulation  
2718 Mail Service Center  
Raleigh, NC 27699-2718

A follow up visit will be conducted to verify all violations have been corrected. If we can be of further assistance, please call Gloria Locklear, Team Leader at (910)214-0350.

Sincerely,



Keith Hughes  
Facility Compliance Consultant I  
Mental Health Licensure & Certification Section


Cc: Joy Futrell, CEO, Trillium Health Resources LME/MCO  
Fonda Gonzales, Director of Quality Management, Trillium Health Resources LME/MCO  
Pam Pridgen, Administrative Supervisor

**STATE FORM: REVISIT REPORT**

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER mhl007-058	Y1	MULTIPLE CONSTRUCTION A. Building B. Wing	Y2	DATE OF REVISIT 3/10/2023	Y3
NAME OF FACILITY COUNTRY LIVING GUEST HOME #5			STREET ADDRESS, CITY, STATE, ZIP CODE 204 STEWART DRIVE WASHINGTON, NC 27889		

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix V0736	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # 27G .0303(c)	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____	03/10/2023	LSC _____		LSC _____	
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____		LSC _____		LSC _____	

REVIEWED BY STATE AGENCY <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR 	DATE 3/10/23
REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 1/18/2022		<input type="checkbox"/> CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? <input type="checkbox"/> YES <input type="checkbox"/> NO		