PRINTED: 09/21/2023 FORM APPROVED

Division of Health Service Regulation

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |                                                                                                                                                                                                                          | ` ′                                                                                                         | CONSTRUCTION        | (X3) DATE SURVEY<br>COMPLETED                                                                                                                                                                                                  |        |                      |
|-----------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------|---------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------|----------------------|
| ANDILAN                                                                                             | or dortheories                                                                                                                                                                                                           | IDENTIFICATION NOMBER.                                                                                      | A. BUILDING: _      | A. BUILDING:                                                                                                                                                                                                                   |        |                      |
|                                                                                                     |                                                                                                                                                                                                                          | MHL0411129                                                                                                  | B. WING             | B. WING                                                                                                                                                                                                                        |        | 3                    |
| NAME OF P                                                                                           | ROVIDER OR SUPPLIER                                                                                                                                                                                                      | STREET ADD                                                                                                  | DRESS, CITY, STA    | TE, ZIP CODE                                                                                                                                                                                                                   |        |                      |
| PERSON                                                                                              | CENTERED CARE                                                                                                                                                                                                            | 3000 TWIN                                                                                                   | LAKES DRIVE         | ≣                                                                                                                                                                                                                              |        |                      |
|                                                                                                     |                                                                                                                                                                                                                          | GREENSB                                                                                                     | ORO, NC 2740        | )7<br>                                                                                                                                                                                                                         |        |                      |
| (X4) ID<br>PREFIX<br>TAG                                                                            | (EACH DEFICIENC                                                                                                                                                                                                          | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)                              | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE APPROPRIED TO THE APPROPRIED CONTROL OF THE APPROPRIED CONTROL OF THE APPROPRIED CONTROL OF THE APPROPRIED CONTROL OF T | BE COM | X5)<br>IPLETE<br>ATE |
| V 000                                                                                               | INITIAL COMMENTS                                                                                                                                                                                                         |                                                                                                             | V 000               |                                                                                                                                                                                                                                |        |                      |
|                                                                                                     | Deficiencies were cite                                                                                                                                                                                                   |                                                                                                             |                     |                                                                                                                                                                                                                                |        |                      |
|                                                                                                     |                                                                                                                                                                                                                          | d for the following service<br>27G .5600F Supervised<br>mily Living.                                        |                     |                                                                                                                                                                                                                                |        |                      |
|                                                                                                     | -                                                                                                                                                                                                                        | d for 2 and currently has a<br>rey sample consisted of<br>ents.                                             |                     |                                                                                                                                                                                                                                |        |                      |
| V 536                                                                                               | 27E .0107 Client Rigl<br>Int.                                                                                                                                                                                            | nts - Training on Alt to Rest.                                                                              | V 536               |                                                                                                                                                                                                                                |        |                      |
|                                                                                                     | 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 |                                                                                                             |                     |                                                                                                                                                                                                                                |        |                      |
|                                                                                                     | other strategies for cr<br>which the likelihood of                                                                                                                                                                       | communication skills and<br>reating an environment in<br>if imminent danger of abuse                        |                     |                                                                                                                                                                                                                                |        |                      |
|                                                                                                     | property damage is p (c) Provider agencies                                                                                                                                                                               | vith disabilities or others or<br>revented.<br>s shall establish training<br>etencies, monitor for internal |                     |                                                                                                                                                                                                                                |        |                      |
|                                                                                                     | gathered.                                                                                                                                                                                                                | onstrate they acted on data be competency-based,                                                            |                     |                                                                                                                                                                                                                                |        |                      |
|                                                                                                     | include measurable le                                                                                                                                                                                                    | earning objectives,                                                                                         |                     |                                                                                                                                                                                                                                |        |                      |
|                                                                                                     | behavior) on those of                                                                                                                                                                                                    | vritten and by observation of<br>ojectives and measurable<br>e passing or failing the                       |                     |                                                                                                                                                                                                                                |        |                      |
|                                                                                                     |                                                                                                                                                                                                                          |                                                                                                             |                     |                                                                                                                                                                                                                                |        |                      |

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

(X6) DATE TITLE

| DIVISION    | n nealth Service Negu                   | iation                         |                  |                                                |              |                  |
|-------------|-----------------------------------------|--------------------------------|------------------|------------------------------------------------|--------------|------------------|
| STATEMENT   | OF DEFICIENCIES                         | (X1) PROVIDER/SUPPLIER/CLIA    | (X2) MULTIPLE    | CONSTRUCTION                                   | (X3) DATE SU | JRVEY            |
| AND PLAN (  | OF CORRECTION                           | IDENTIFICATION NUMBER:         | A. BUILDING:     |                                                | COMPLE       | TED              |
|             |                                         |                                | 1                |                                                |              |                  |
|             |                                         |                                |                  |                                                |              |                  |
| MHL0411129  |                                         |                                | B. WING          | <del></del>                                    | 09/07        | 7/2023           |
| NAME OF D   | ROVIDER OR SUPPLIER                     | STDEET AP                      | DRESS, CITY, STA | TE ZIR CODE                                    |              |                  |
| TVAINE OF T | NOVIDER OR GOLT EIER                    |                                |                  |                                                |              |                  |
| PERSON (    | CENTERED CARE                           |                                | N LAKES DRIVE    |                                                |              |                  |
|             |                                         | GREENSI                        | 3ORO, NC 2740    | 07                                             |              |                  |
| (X4) ID     |                                         | ATEMENT OF DEFICIENCIES        | ID               | PROVIDER'S PLAN OF CORRECTIO                   |              | (X5)             |
| PREFIX      |                                         | Y MUST BE PRECEDED BY FULL     | PREFIX           | (EACH CORRECTIVE ACTION SHOULD                 |              | COMPLETE<br>DATE |
| TAG         | REGULATORT OR I                         | LSC IDENTIFYING INFORMATION)   | TAG              | CROSS-REFERENCED TO THE APPROPI<br>DEFICIENCY) | RIAIE        | DAIL             |
|             |                                         |                                |                  | ,                                              |              |                  |
| V 536       | Continued From page                     | e 1                            | V 536            |                                                |              |                  |
|             | (a) <b>F</b> armani na <b>f</b> aranian | Anninin in a constant          |                  |                                                |              |                  |
|             | ` '                                     | training must be completed     |                  |                                                |              |                  |
|             | •                                       | der periodically (minimum      |                  |                                                |              |                  |
|             | annually).                              |                                |                  |                                                |              |                  |
|             | (f) Content of the trai                 |                                |                  |                                                |              |                  |
|             | · ·                                     | nploy must be approved by      |                  |                                                |              |                  |
|             | the Division of MH/DI                   | •                              |                  |                                                |              |                  |
|             | Paragraph (g) of this                   |                                |                  |                                                |              |                  |
|             |                                         | strate competence in the       |                  |                                                |              |                  |
|             | following core areas:                   |                                |                  |                                                |              |                  |
|             | • •                                     | and understanding of the       |                  |                                                |              |                  |
|             | people being served;                    |                                |                  |                                                |              |                  |
|             | (2) recognizing                         | and interpreting human         |                  |                                                |              |                  |
|             | behavior;                               |                                |                  |                                                |              |                  |
|             | ` ,                                     | the effect of internal and     |                  |                                                |              |                  |
|             | external stressors that                 | at may affect people with      |                  |                                                |              |                  |
|             | disabilities;                           |                                |                  |                                                |              |                  |
|             | (4) strategies for                      | or building positive           |                  |                                                |              |                  |
|             | relationships with per                  | sons with disabilities;        |                  |                                                |              |                  |
|             | (5) recognizing                         | cultural, environmental and    |                  |                                                |              |                  |
|             | organizational factors                  | that may affect people with    |                  |                                                |              |                  |
|             | disabilities;                           |                                |                  |                                                |              |                  |
|             | (6) recognizing                         | the importance of and          |                  |                                                |              |                  |
|             | assisting in the perso                  | n's involvement in making      |                  |                                                |              |                  |
|             | decisions about their                   | life;                          |                  |                                                |              |                  |
|             | (7) skills in ass                       | essing individual risk for     |                  |                                                |              |                  |
|             | escalating behavior;                    | -                              |                  |                                                |              |                  |
|             | •                                       | tion strategies for defusing   |                  |                                                |              |                  |
|             |                                         | tentially dangerous behavior;  |                  |                                                |              |                  |
|             | and                                     | , 3,                           |                  |                                                |              |                  |
|             |                                         | navioral supports (providing   |                  |                                                |              |                  |
|             | . ,                                     | h disabilities to choose       |                  |                                                |              |                  |
|             | activities which direct                 |                                |                  |                                                |              |                  |
|             | behaviors which are u                   | •                              |                  |                                                |              |                  |
|             | (h) Service providers                   | ,                              |                  |                                                |              |                  |
|             |                                         | al and refresher training for  |                  |                                                |              |                  |
|             | at least three years.                   | a. a.ia foiroonor training for |                  |                                                |              |                  |
|             | _                                       | tion shall include:            |                  |                                                |              |                  |
|             | ` '                                     | ated in the training and the   |                  |                                                |              |                  |
|             | outcomes (pass/fail);                   | ated in the training and the   |                  |                                                |              |                  |

Division of Health Service Regulation

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| DIVISION   | n Health Service Regu    | ialion                           | 1                |                                               |             |          |
|------------|--------------------------|----------------------------------|------------------|-----------------------------------------------|-------------|----------|
| STATEMENT  | OF DEFICIENCIES          | (X1) PROVIDER/SUPPLIER/CLIA      | (X2) MULTIPLE    | CONSTRUCTION                                  | (X3) DATE S | URVEY    |
| AND PLAN C | F CORRECTION             | IDENTIFICATION NUMBER:           | A. BUILDING:     |                                               | COMPLI      | ETED     |
|            |                          |                                  |                  |                                               |             |          |
|            |                          |                                  |                  |                                               |             |          |
| MHL0411129 |                          |                                  | B. WING          |                                               | 09/0        | 7/2023   |
| NAME OF D  | ROVIDER OR SUPPLIER      | STREET AD                        | DRESS, CITY, STA | TE ZIR CODE                                   |             |          |
| NAME OF T  | TOVIDER OR SOLT EIER     |                                  |                  |                                               |             |          |
| PERSON (   | CENTERED CARE            |                                  | I LAKES DRIVE    |                                               |             |          |
|            |                          | GREENSE                          | BORO, NC 2740    | 07                                            |             |          |
| (X4) ID    | SUMMARY STA              | ATEMENT OF DEFICIENCIES          | ID               | PROVIDER'S PLAN OF CORRECTION                 | ON          | (X5)     |
| PREFIX     |                          | Y MUST BE PRECEDED BY FULL       | PREFIX           | (EACH CORRECTIVE ACTION SHOULD                |             | COMPLETE |
| TAG        | REGULATORY OR L          | LSC IDENTIFYING INFORMATION)     | TAG              | CROSS-REFERENCED TO THE APPROF<br>DEFICIENCY) | RIATE       | DATE     |
|            |                          |                                  | 1                | DEFICIENCY)                                   |             |          |
| V 536      | Continued From page      | e 2                              | V 536            |                                               |             |          |
|            |                          |                                  |                  |                                               |             |          |
|            |                          | vhere they attended; and         |                  |                                               |             |          |
|            | (C) instructor's         | name;                            |                  |                                               |             |          |
|            | (2) The Division         | n of MH/DD/SAS may               |                  |                                               |             |          |
|            | ` '                      | ocumentation at any time.        |                  |                                               |             |          |
|            | (i) Instructor Qualifica |                                  |                  |                                               |             |          |
|            | Requirements:            | anono ana maning                 |                  |                                               |             |          |
|            |                          | all demonstrate competence       |                  |                                               |             |          |
|            |                          | ·                                |                  |                                               |             |          |
|            | , ,                      | esting in a training program     |                  |                                               |             |          |
|            |                          | reducing and eliminating the     |                  |                                               |             |          |
|            | need for restrictive int |                                  |                  |                                               |             |          |
|            | (2) Trainers sha         | all demonstrate competence       |                  |                                               |             |          |
|            | by scoring a passing     | grade on testing in an           |                  |                                               |             |          |
|            | instructor training pro- | gram.                            |                  |                                               |             |          |
|            | (3) The training         | shall be                         |                  |                                               |             |          |
|            |                          | nclude measurable learning       |                  |                                               |             |          |
|            |                          | le testing (written and by       |                  |                                               |             |          |
|            | •                        | ior) on those objectives and     |                  |                                               |             |          |
|            |                          | to determine passing or          |                  |                                               |             |          |
|            | failing the course.      | to determine passing or          |                  |                                               |             |          |
|            |                          | t of the inetruster training the |                  |                                               |             |          |
|            | ` '                      | t of the instructor training the |                  |                                               |             |          |
|            | service provider plans   |                                  |                  |                                               |             |          |
|            |                          | sion of MH/DD/SAS pursuant       |                  |                                               |             |          |
|            | to Subparagraph (i)(5    |                                  |                  |                                               |             |          |
|            | (5) Acceptable           | instructor training programs     |                  |                                               |             |          |
|            | shall include but are r  | not limited to presentation of:  |                  |                                               |             |          |
|            | (A) understandi          | ng the adult learner;            |                  |                                               |             |          |
|            |                          | r teaching content of the        |                  |                                               |             |          |
|            | course;                  | -                                |                  |                                               |             |          |
|            | •                        | r evaluating trainee             |                  |                                               |             |          |
|            | performance; and         | •                                |                  |                                               |             |          |
|            |                          | ion procedures.                  |                  |                                               |             |          |
|            |                          | all have coached experience      |                  |                                               |             |          |
|            | ` '                      | ogram aimed at preventing,       |                  |                                               |             |          |
|            |                          |                                  |                  |                                               |             |          |
|            |                          | ting the need for restrictive    |                  |                                               |             |          |
|            |                          | one time, with positive          |                  |                                               |             |          |
|            | review by the coach.     |                                  |                  |                                               |             |          |
|            |                          | all teach a training program     |                  |                                               |             |          |
|            | aimed at preventing, i   | reducing and eliminating the     |                  |                                               |             |          |
|            |                          | terventions at least once        |                  |                                               |             |          |

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|                          | STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                               | (X2) MULTIPLE (<br>A. BUILDING:  | CONSTRUCTION                                                                 |                                   | E SURVEY<br>PLETED       |
|--------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|------------------------------------------------------------------------------|-----------------------------------|--------------------------|
|                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | MHL0411129                                                                                                                                                                                                                                                                                                                                                                    | B. WING                          |                                                                              | 09                                | /07/2023                 |
| NAME OF P                | ROVIDER OR SUPPLIER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | STREET A                                                                                                                                                                                                                                                                                                                                                                      | DDRESS, CITY, STAT               | E, ZIP CODE                                                                  |                                   |                          |
| PERSON                   | CENTERED CARE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                               | IN LAKES DRIVE<br>BORO, NC 27407 | 7                                                                            |                                   |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | TATEMENT OF DEFICIENCIES<br>CY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                       | ID<br>PREFIX<br>TAG              | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE AC<br>CROSS-REFERENCED TO<br>DEFICIEN | TION SHOULD BE<br>THE APPROPRIATE | (X5)<br>COMPLETE<br>DATE |
| V 536                    | annually.  (8) Trainers shinstructor training at  (j) Service providers documentation of init training for at least th  (1) Docum  (A) who participoutcomes (pass/fail);  (B) when and (C) instructor's  (2) The Division request and review th  (k) Qualifications of  (1) Coaches some requirements as a train-the-trainer instructory train-the-trainer shinstructory train-the-trainer shi | nall complete a refresher least every two years. shall maintain tial and refresher instructor nree years. entation shall include: cated in the training and the swhere attended; and s name. on of MH/DD/SAS may his documentation any time. Coaches: hall meet all preparation ainer. hall teach at least three times being coached. hall demonstrate pletion of coaching or | V 536                            |                                                                              |                                   |                          |
|                          | failed to ensure form alternatives to restric completed at least at                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | as evidenced by: iew and interview, the facility al refresher training on ctive interventions was nnually affecting 1 of 3 alified Professional (QP)).                                                                                                                                                                                                                        |                                  |                                                                              |                                   |                          |

Division of Health Service Regulation

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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |                                                                                                                                                                                                                                                                                                                                                                                          | (X2) MULTIPLE C A. BUILDING:                                                                                                                                                                                                                                                                                                                                                                                        |                      | , ,                                                                                        | E SURVEY<br>PLETED           |                          |
|-----------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------|--------------------------------------------------------------------------------------------|------------------------------|--------------------------|
|                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                     |                      |                                                                                            |                              |                          |
|                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                          | MHL0411129                                                                                                                                                                                                                                                                                                                                                                                                          | B. WING              |                                                                                            | 09                           | 0/07/2023                |
| NAME OF P                                                                                           | ROVIDER OR SUPPLIER                                                                                                                                                                                                                                                                                                                                                                      | STREET                                                                                                                                                                                                                                                                                                                                                                                                              | ADDRESS, CITY, STATE | E, ZIP CODE                                                                                |                              |                          |
| PERSON                                                                                              | CENTERED CARE                                                                                                                                                                                                                                                                                                                                                                            | 3000 TV                                                                                                                                                                                                                                                                                                                                                                                                             | VIN LAKES DRIVE      |                                                                                            |                              |                          |
| PERSON                                                                                              | CENTERED CARE                                                                                                                                                                                                                                                                                                                                                                            | GREEN                                                                                                                                                                                                                                                                                                                                                                                                               | SBORO, NC 27407      |                                                                                            |                              |                          |
| (X4) ID<br>PREFIX<br>TAG                                                                            | (EACH DEFICIENC                                                                                                                                                                                                                                                                                                                                                                          | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>.SC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                               | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CO<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE<br>DEFICIENCY) | N SHOULD BE<br>E APPROPRIATE | (X5)<br>COMPLETE<br>DATE |
| V 536                                                                                               | Continued From page                                                                                                                                                                                                                                                                                                                                                                      | e 4                                                                                                                                                                                                                                                                                                                                                                                                                 | V 536                |                                                                                            |                              |                          |
|                                                                                                     | -A hire date of 9/5/11<br>-A job description of 0<br>-Annual training on al<br>interventions expired                                                                                                                                                                                                                                                                                     | ternatives to restrictive<br>on 3/22/23<br>aining on alternatives to                                                                                                                                                                                                                                                                                                                                                |                      |                                                                                            |                              |                          |
|                                                                                                     | Interview on 9/7/23 w -Was aware that her a alternatives to restrict expired on 3/22/23 -Planned to complete end of September 20                                                                                                                                                                                                                                                         | annual training on<br>iive interventions had<br>the required training by the                                                                                                                                                                                                                                                                                                                                        |                      |                                                                                            |                              |                          |
| V 537                                                                                               | 27E .0108 Client RigI                                                                                                                                                                                                                                                                                                                                                                    | nts - Training in Sec Rest &                                                                                                                                                                                                                                                                                                                                                                                        | V 537                |                                                                                            |                              |                          |
|                                                                                                     | ISOLATION TIME-OU (a) Seclusion, physic time-out may be emp been trained and hav competence in the pr to these procedures. staff authorized to emprocedures are retraicompetence at least (b) Prior to providing disabilities whose treincludes restrictive in service providers, emvolunteers shall compseclusion, physical reand shall not use the training is completed demonstrated. | CAL RESTRAINT AND JT cal restraint and isolation loyed only by staff who have e demonstrated oper use of and alternatives Facilities shall ensure that aploy and terminate these ned and have demonstrated annually. direct care to people with atment/habilitation plan terventions, staff including aployees, students or olete training in the use of estraint and isolation time-out se interventions until the |                      |                                                                                            |                              |                          |

Division of Health Service Regulation

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| NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  3000 TWIN LAKES DRIVE GREENSBORO, NC 27407   (X4) ID PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  B. WING B. WINC B. WING B. WING B. WING B. WINC B. WING B. WINC B. WING B. WINC B. WINC B. WING B. WINC B. WI |            | STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | (X2) MULTIPLE CONSTRUCTION  A. BUILDING: |                                | (X3) DATE SURVEY<br>COMPLETED |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------|--------------------------------|-------------------------------|--|
| NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  PERSON CENTERED CARE  3000 TWIN LAKES DRIVE GREENSBORO, NC 27407   (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  STREET ADDRESS, CITY, STATE, ZIP CODE  3000 TWIN LAKES DRIVE GREENSBORO, NC 27407   (X5) PREFIX (EACH CORRECTION SHOULD BE COMPLETED AND CROSS-REFERENCED TO THE APPROPRIATE DATE)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                          |                                |                               |  |
| PERSON CENTERED CARE  3000 TWIN LAKES DRIVE GREENSBORO, NC 27407  (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  3000 TWIN LAKES DRIVE GREENSBORO, NC 27407  ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE COMPLE' TAG CROSS-REFERENCED TO THE APPROPRIATE  DATE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | MHL0411129 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | B. WING                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                          | 09/07/2023                     |                               |  |
| PERSON CENTERED CARE  GREENSBORO, NC 27407  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLE' TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | NAME OF PI | ROVIDER OR SUPPLIER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | STREET AD                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | DRESS, CITY, STA                         | TE, ZIP CODE                   |                               |  |
| (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLE' TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | PERSON     | CENTERED CARE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 3000 TWI                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | N LAKES DRIVE                            | <b></b>                        |                               |  |
| PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLE TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG CROSS-REFERENCED TO THE APPROPRIATE  DATE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | GREENSE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | BORO, NC 2740                            | <b>07</b>                      |                               |  |
| 22.102.10                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | PREFIX     | (EACH DEFICIENC                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Y MUST BE PRECEDED BY FULL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | PREFIX                                   | (EACH CORRECTIVE ACTION SHOULD | BE COMPLE                     |  |
| V 537 Continued From page 5                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | V 537      | Continued From page                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | e 5                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | V 537                                    |                                |                               |  |
| demonstrating competence by completion of training in preventing, reducing and eliminating the need for restrictive interventions.  (d) The training shall be competency-based, include measurable learning objectives, 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 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                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | V 537      | demonstrating competraining in preventing the need for restrictive (d) The training shall include measurable testing (videnavior) on those of methods to determine course.  (e) Formal refresher by each service proviannually).  (f) Content of the training provider plans to empthe Division of MH/DD Paragraph (g) of this (g) Acceptable training but are not limited to, (1) refresher in the use of restrictive in (2) guidelines of (understanding imminothers);  (3) emphasis or rights and dignity of a concepts of least restincemental steps in a (4) strategies for of restrictive interventions which in assessment and more psychological well-be use of restrictive intervention (6) prohibited profiles (7) debriefing signal includes (7) | etence by completion of reducing and eliminating e interventions. be competency-based, earning objectives, written and by observation of objectives and measurable e passing or failing the training must be completed der periodically (minimum ning that the service oloy must be approved by D/SAS pursuant to Rule. In a programs shall include, presentation of: formation on alternatives to interventions; on when to intervene ment danger to self and in safety and respect for the all persons involved (using rictive interventions and an intervention); or the safe implementation cions; emergency safety include continuous elitoring of the physical and ing of the client and the safe ghout the duration of the n; procedures; trategies, including their | V 337                                    |                                |                               |  |

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|                          | STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | I ' '               | CONSTRUCTION                                                                                                      | (X3) DATE SURVEY<br>COMPLETED |  |
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|                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | MHL0411129                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | B. WING             |                                                                                                                   | 09/07/2023                    |  |
| NAME OF D                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | DRESS, CITY, STA    | TE 710 CODE                                                                                                       | 1 00/01/2020                  |  |
| NAME OF T                | ROVIDER OR SUPPLIER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | N LAKES DRIVE       | •                                                                                                                 |                               |  |
| PERSON                   | CENTERED CARE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | BORO, NC 2740       |                                                                                                                   |                               |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPE<br>DEFICIENCY) | BE COMPLETE                   |  |
| V 537                    | Continued From page                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | <del>2</del> 6                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | V 537               |                                                                                                                   |                               |  |
|                          | (h) Service providers documentation of initi at least three years.  (1) Documentation of initi at least three years.  (1) Documentation of initi at least three years.  (1) Documentation of initi at least three years.  (2) When and with the content of the conten | shall maintain al and refresher training for tion shall include: ated in the training and the where they attended; and name. In of MH/DD/SAS may be cumentation at any time. The ation and Training all demonstrate competence the esting in a training program reducing and eliminating the terventions. The ation is a training program reducing and eliminating the terventions. The ation is a training program reclusion, physical restraint it. The ation and training in an an in a training program reclusion, physical restraint it. The ation is a training program reclusion, physical restraint it. The ation is a training in an in an in a training |                     |                                                                                                                   |                               |  |

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 1 '                 | CONSTRUCTION                                                                                                      | (X3) DATE SURVEY<br>COMPLETED |  |
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|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | A. BOILDING         | <del></del>                                                                                                       |                               |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | MHL0411129                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | B. WING             |                                                                                                                   | 09/07/2023                    |  |
| NAME OF PROVIDER OR SUPPLIER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | STREET ADD                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | RESS, CITY, STA     | TE, ZIP CODE                                                                                                      |                               |  |
| PERSON CENTERED CARE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 3000 TWIN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | LAKES DRIVE         | <b></b>                                                                                                           |                               |  |
| PERSON CENTERED CARE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | GREENSB                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | ORO, NC 2740        | 07                                                                                                                |                               |  |
| PREFIX (EACH DEFIC                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | Y STATEMENT OF DEFICIENCIES<br>ENCY MUST BE PRECEDED BY FULL<br>OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPR<br>DEFICIENCY) | BE COMPLETE                   |  |
| V 537 Continued From p                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | age 7                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | V 537               |                                                                                                                   |                               |  |
| (C) evaluat (D) docume (7) Trainers annually and dem of seclusion, phys time-out, as speci Rule. (8) Trainers CPR. (9) Trainers in teaching the us least two times wi coach. (10) Trainers use of restrictive i annually. (11) Trainers instructor training (k) Service provio documentation of training for at leas (1) Docume (A) who par outcome (pass/fa (B) when ai (C) instruct (2) The Div review/request thi (I) Qualifications (1) Coache requirements as a (2) Coache times, the course (3) Coache competence by co | on of trainee performance; and natation procedures. shall be retrained at least constrate competence in the use ical restraint and isolation fied in Paragraph (a) of this shall be currently trained in shall have coached experience to of restrictive interventions at the apositive review by the shall teach a program on the interventions at least once shall complete a refresher at least every two years. The initial and refresher instructor at three years. Intation shall include: icipated in the training and the or's name. Sion of MH/DD/SAS may a documentation at any time. In trainer. It is shall teach at least three which is being coached. It is shall teach at least three which is being coached. It is shall demonstrate impletion of coaching or struction. In shall be the same |                     |                                                                                                                   |                               |  |

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|                          | OF DEFICIENCIES                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | (X1) PROVIDER/SUPPLIER/CLIA                                                                                                                                                                                                                                                                                                          | (X2) MULTIPLE       | CONSTRUCTION                                                                                                      | (X3) DATE SURVEY |  |
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| AND PLAN (               | OF CORRECTION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | IDENTIFICATION NUMBER:                                                                                                                                                                                                                                                                                                               | A. BUILDING:        |                                                                                                                   | COMPLETED        |  |
|                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                      |                     |                                                                                                                   |                  |  |
|                          | MHL0411129                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                      | B. WING             |                                                                                                                   | 09/07/2023       |  |
| NAME OF PI               | ROVIDER OR SUPPLIER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | STREET ADD                                                                                                                                                                                                                                                                                                                           | RESS, CITY, STA     | TE, ZIP CODE                                                                                                      |                  |  |
|                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 3000 TWIN                                                                                                                                                                                                                                                                                                                            | LAKES DRIVE         | <u> </u>                                                                                                          |                  |  |
| PERSON (                 | CENTERED CARE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | GREENSB                                                                                                                                                                                                                                                                                                                              | ORO, NC 2740        | 7                                                                                                                 |                  |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>.SC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPF<br>DEFICIENCY) | BE COMPLETE      |  |
| V 537                    | Continued From page                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | <u>.</u> 8                                                                                                                                                                                                                                                                                                                           | V 537               |                                                                                                                   |                  |  |
|                          | This Rule is not met a Based on record reviet failed to ensure former seclusion, physical retime-out was complet affecting 1 of 3 audited Professional (QP)). The Review on 9/7/23 of the Ahire date of 9/5/11 and isolation time-out and isolation time-out and isolation time-out restraint, and isolation Interview on 9/7/23 with the Rule Based on 10 audit and | as evidenced by: ew and interview, the facility er refresher training in straint, and isolation ed at least annually ed staff (the Qualified the findings are: the QP's record revealed: QP clusion, physical restraint expired on 3/22/23 aining in seclusion, physical on time-out ith the QP revealed: ed the clients, but we are |                     |                                                                                                                   |                  |  |
|                          | on 3/22/23                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | ive intervention had expired the required training by the                                                                                                                                                                                                                                                                            |                     |                                                                                                                   |                  |  |
| V 736                    | ·                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | and Grounds Maintenance                                                                                                                                                                                                                                                                                                              | V 736               |                                                                                                                   |                  |  |
|                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | EMENTS                                                                                                                                                                                                                                                                                                                               |                     |                                                                                                                   |                  |  |

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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |                                                                                                                                                                                                                                                                                  | (X2) MULTIPLE                                                                                        | CONSTRUCTION        | (X3) DATE S                                                                                                     |       |                          |
|-----------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|---------------------|-----------------------------------------------------------------------------------------------------------------|-------|--------------------------|
| AND PLAN                                                                                            | OF CORRECTION                                                                                                                                                                                                                                                                    | IDENTIFICATION NOMBER.                                                                               | A. BUILDING: _      |                                                                                                                 | COMPL | EIED                     |
|                                                                                                     |                                                                                                                                                                                                                                                                                  | MHL0411129                                                                                           | B. WING             |                                                                                                                 | 09/0  | 7/2023                   |
| NAME OF P                                                                                           | ROVIDER OR SUPPLIER                                                                                                                                                                                                                                                              | STREET ADD                                                                                           | DRESS, CITY, STA    | TE, ZIP CODE                                                                                                    |       |                          |
| DEDCON                                                                                              | OFNITEDED CADE                                                                                                                                                                                                                                                                   | 3000 TWIN                                                                                            | LAKES DRIVE         | <b></b>                                                                                                         |       |                          |
| PERSON                                                                                              | CENTERED CARE                                                                                                                                                                                                                                                                    | GREENSB                                                                                              | ORO, NC 2740        | 7                                                                                                               |       |                          |
| (X4) ID<br>PREFIX<br>TAG                                                                            | (EACH DEFICIENC)                                                                                                                                                                                                                                                                 | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>.SC IDENTIFYING INFORMATION)                | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOULE<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | ) BE  | (X5)<br>COMPLETE<br>DATE |
| V 736                                                                                               | Continued From page                                                                                                                                                                                                                                                              | 9                                                                                                    | V 736               |                                                                                                                 |       |                          |
|                                                                                                     | This Rule is not met<br>Based on observation<br>and its grounds were<br>clean, and attractive r                                                                                                                                                                                  |                                                                                                      |                     |                                                                                                                 |       |                          |
|                                                                                                     | of the facility revealed<br>-The back door's scre-<br>left side, that caused                                                                                                                                                                                                     | d:<br>een was torn 2 inches on the<br>the screen to become                                           |                     |                                                                                                                 |       |                          |
|                                                                                                     | unsecured on the door frame -There was a green like substance on the vinyl siding outside of the facility approximately 4 feet in length, 2 feet in width on the left side of the facility                                                                                       |                                                                                                      |                     |                                                                                                                 |       |                          |
|                                                                                                     | inside of the facility re-<br>-The facility was a spl                                                                                                                                                                                                                            | on 9/7/23 at 8:18am of the evealed:<br>lit-level home with 7 stairs<br>s and 7 stairs leading to the |                     |                                                                                                                 |       |                          |
|                                                                                                     | -The handrail that led to the downstairs was loose -The 1st step which lead to the downstairs was missing a 12-inch by 4-inch section of carpet -The 6 panel closet door downstairs had 4 different cracked areas, which ranged in sizes                                         |                                                                                                      |                     |                                                                                                                 |       |                          |
|                                                                                                     | the upper left panel -In client #1's bedroor                                                                                                                                                                                                                                     | er and 2 inches in length, in m, the upper top left area of a 2 inch by 3 inch crack                 |                     |                                                                                                                 |       |                          |
|                                                                                                     | 3 dried reddish streak inches long to 1 inch                                                                                                                                                                                                                                     |                                                                                                      |                     |                                                                                                                 |       |                          |
|                                                                                                     | -The door frame to client #1's bedroom was separated from the door which created a one-inch gap -In client's #2's bedroom, on the inside of one of the windows, there were spider webs, dust and several dried broken leaves -One of the sliding doors to client #2's closet was |                                                                                                      |                     |                                                                                                                 |       |                          |
|                                                                                                     | missing, and the othe                                                                                                                                                                                                                                                            | r sliding door was off track                                                                         |                     |                                                                                                                 |       |                          |

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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                              | CONSTRUCTION                  | (X3) DATE S                                                                  |       |                  |
|-----------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------|-------------------------------|------------------------------------------------------------------------------|-------|------------------|
|                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                              | A. BUILDING: _                |                                                                              |       |                  |
|                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                          | MHL0411129                                                   | B. WING                       |                                                                              | 09/0  | 7/2023           |
| NAME OF P                                                                                           | ROVIDER OR SUPPLIER                                                                                                                                                                                                                                                                                                                                                                                                                                      | STREET ADD                                                   | DRESS, CITY, STA              | TE, ZIP CODE                                                                 |       |                  |
| PERSON                                                                                              | CENTERED CARE                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                              | I LAKES DRIVE<br>ORO, NC 2740 |                                                                              |       |                  |
| (X4) ID                                                                                             | SUMMARY ST                                                                                                                                                                                                                                                                                                                                                                                                                                               | ATEMENT OF DEFICIENCIES                                      | ID ID                         | PROVIDER'S PLAN OF CORRECT                                                   | ON    | (X5)             |
| PREFIX<br>TAG                                                                                       | (EACH DEFICIENC                                                                                                                                                                                                                                                                                                                                                                                                                                          | Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)    | PREFIX<br>TAG                 | (EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | _D BE | COMPLETE<br>DATE |
| V 736                                                                                               | Continued From page                                                                                                                                                                                                                                                                                                                                                                                                                                      | e 10                                                         | V 736                         |                                                                              |       |                  |
|                                                                                                     | -The clients' downsta<br>lights, 2 of which were                                                                                                                                                                                                                                                                                                                                                                                                         | irs' bathroom vanity had 4<br>e missing lightbulbs           |                               |                                                                              |       |                  |
|                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                          | on 9/7/23 with client #1 and ccessful due to their inability |                               |                                                                              |       |                  |
|                                                                                                     | Interview on 9/7/23 with the Qualified Professional revealed: -"I can remember mentioning to her (the Licensee) some tree limbs needed to be picked up and some needed to be trimmed back. She is constantly having to make repairs to the house. The clients' behaviors include property destruction. One client picks at things and the other client kicks and punches holes in the walls." -Was not aware one of client #2's closet doors was missing |                                                              |                               |                                                                              |       |                  |
|                                                                                                     | -She was aware of so<br>outside of the facility<br>- "I know the doors do<br>replaced. I have been<br>patching them."<br>-Concerning the hand<br>that up. I just put new<br>rails a couple of mont<br>put their weight on it.<br>it and swing their way                                                                                                                                                                                                  |                                                              |                               |                                                                              |       |                  |

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