	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C		(X3) DATE SURVEY COMPLETED	
		MHL041-837	B. WING		02/12/2024	
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE		
BISBEE P	LACE		BEE DRIVE BORO, NC 27407			
			BURU, NC 2/40/			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPL	
V 000	INITIAL COMMENTS	3	V 000			
	An annual survey wa 2024. Deficiencies we	s completed on February 12, ere cited.				
		d for the following service 27G .1700 Residential re for Children and				
		d for 4 and currently has a vey sample consisted of ients.				
V 536	27E .0107 Client Rigi Int.	hts - Training on Alt to Rest.	V 536			
	to restrictive intervent (b) Prior to providing disabilities, staff inclu employees, students demonstrate compete completing training in other strategies for cr which the likelihood co or injury to a person of property damage is p (c) Provider agencies based on state comp compliance and demo gathered. (d) The training shall include measurable le measurable testing (v behavior) on those of	RESTRICTIVE plement policies and size the use of alternatives tions. services to people with iding service providers, or volunteers, shall ence by successfully a communication skills and reating an environment in of imminent danger of abuse with disabilities or others or vrevented. s shall establish training etencies, monitor for internal onstrate they acted on data be competency-based,		Pursuant to 27E.27E.010 TAG (V-536) Clients Righ Training on Alternative to Restraint Intervention - First Genesis Family Ser will ensure that the LP, as as all other staff members all required Training on Alternative to Restrictive Interventions per the administrative rule. First Genesis Family Services complete all required train within 60 days from the e the survey, which is April 2024. It is, and shall be, policy of First Genesis Fa Services to use restraints seclusion as the very last option.	will ning xit of 12, the umily and	

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		MHL041-837			02	2/12/2024
NAME OF PF	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE,	, ZIP CODE		
BISBEE PI	LACE		SBEE DRIVE SBORO, NC 27407			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE
V 536	Continued From pag	e 1	V 536			
	course.					
	(e) Formal refresher	training must be completed				
		ider periodically (minimum				
	annually).					
		ining that the service				
	provider wishes to employ must be approved by					
	the Division of MH/DD/SAS pursuant to					
	Paragraph (g) of this Rule. (g) Staff shall demonstrate competence in the					
	following core areas:	-				
	(1) knowledge and understanding of the					
	people being served;					
	(2) recognizing and interpreting human					
	behavior;					
	(3) recognizing the effect of internal and					
	external stressors the	at may affect people with				
	disabilities;					
		or building positive				
		rsons with disabilities;				
		g cultural, environmental and				
	disabilities;	s that may affect people with				
		the importance of and				
	5 1	on's involvement in making				
	decisions about their (7) skills in ass	sessing individual risk for				
	escalating behavior;					
	-	ation strategies for defusing				
		tentially dangerous behavior;				
		havioral supports (providing				
		th disabilities to choose				
		tly oppose or replace				
	behaviors which are	,				
	(h) Service provider					
		tial and refresher training for				
	at least three years.					
	( )	ation shall include:				
	<ul><li>(A) who particip</li></ul>	pated in the training and the				

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		MHL041-837			02	2/12/2024
NAME OF PI	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE		02	2/12/2024
			SBEE DRIVE	,		
BISBEE P	LACE	GREEN	SBORO, NC 27407			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLET DATE
V 536	Continued From page	e 2	V 536			
	outcomes (pass/fail);					
		where they attended; and				
	(C) instructor's					
	(2) The Divisio	n of MH/DD/SAS may				
		ocumentation at any time.				
	(i) Instructor Qualific	ations and Training				
	Requirements:					
	(1) Trainers shall demonstrate competence by scoring 100% on testing in a training program					
	, ,	reducing and eliminating the				
	need for restrictive interventions.					
	(2) Trainers shall demonstrate competence					
	by scoring a passing grade on testing in an					
	instructor training program.					
	(3) The training shall be					
		nclude measurable learning				
	-	ble testing (written and by				
		ior) on those objectives and				
		to determine passing or				
	failing the course. (4) The conten	t of the instructor training the				
	service provider plan					
		sion of MH/DD/SAS pursuant				
	to Subparagraph (i)(5	•				
		instructor training programs				
		not limited to presentation of:				
	. ,	ing the adult learner;				
	• •	or teaching content of the				
	course;					
		or evaluating trainee				
	performance; and (D) documentat	tion procedures.				
		all have coached experience				
		rogram aimed at preventing,				
		ting the need for restrictive				
	-	one time, with positive				
	review by the coach.	-				
		all teach a training program				
	aimed at preventing,					1

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED		
		MHL041-837	B. WING		02	2/12/2024		
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	, ZIP CODE	02/12/20			
BISBEE P	LACE		SBEE DRIVE SBORO, NC 27407					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETI DATE		
V 536	Continued From page	e 3	V 536					
	<ul> <li>annually.</li> <li>(8) Trainers shinstructor training at I</li> <li>(j) Service providers documentation of initial training for at least the (1) Docume (A) who particip outcomes (pass/fail);</li> <li>(B) when and with (C) instructor's</li> <li>(2) The Division request and review the (k) Qualifications of (2) Coaches sharequirements as a train the course which is bid) Coaches sharequirements as a train the trainer instruction of the course which is bid) Coaches share the train the trainer instruction of the course which is bid) This Rule is not met Based on record revising a for trainers.</li> </ul>	ial and refresher instructor iree years. entation shall include: bated in the training and the where attended; and name. n of MH/DD/SAS may his documentation any time. Coaches: hall meet all preparation hiner. hall teach at least three times being coached. hall demonstrate bletion of coaching or luction. hall be the same preparation						

STATEMEN	of Health Service Regu FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:	CONSTRUCTION	(X3) DATE S COMPL	
		MHL041-837	B. WING		02/12/2024	
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	E, ZIP CODE		
BISBEE P	LACE		BORO, NC 27407	,		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
V 536	Review on 2/12/24 of -A hire date of 12/18/ -A job description of I -An expired certificate	the LP's record revealed: 14	V 536			
	-Usually all of her trai -"To be honest with y hospital previously ar Telehealth position an training for the the gr Director/Associate Pr	with the LP revealed: inings were up to date ou, I was working for a nd my current position is a nd I did not think about my oup home. He (Executive rofessional (ED/AP)) said the eduled for the end of the		Pursuant to 27E.0108- TA0		
V 507	-Was responsible for training in alternative -Stated the LP's train April 30th, 2023. -"I just got off the pho sure she attends the beginning of the mon training is due."	with the ED/AP revealed: ensuring all facility staff had s to restrictive interventions ing certificate expired on one with her and I will make training scheduled at the th when the other staffs'	V 527	(V -537)- Training Seclusio Physical Restraint, and Iso Time-Out- Training on Alte to Restraint Intervention First Genesis Family Servi will ensure that the LP, as all other staff members hav required Training on - Train Seclusion, Physical Restra and Isolation Time-Out- Tra on Alternative to Restraint	n, lation rnative ces well as ve all hing int,	To be Complet by Apri 12, 2024
V 537	ITO 10A NCAC 27E .0108 SECLUSION, PHYSI ISOLATION TIME-OU (a) Seclusion, physic time-out may be emp been trained and hav competence in the pr to these procedures.	CAL RESTRAINT AND JT cal restraint and isolation loyed only by staff who have	V 537	Intervention per the administrative rule. All train and corrections will be com within 60 days as required the exit of the survey, which April 12, 2024. It is, and sh the policy of First Genesis Services to never use - Tra Seclusion, Physical Restra and Isolation Time-Out only the very last option.	pleted from h is all be, Family ining int,	

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
			A. BUILDING:			
		MHL041-837 B. WING			02	2/12/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
BISBEE P	PLACE		SBEE DRIVE SBORO, NC 27407			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
V 537	Continued From page	e 5	V 537			
	competence at least a (b) Prior to providing disabilities whose trea- includes restrictive in service providers, err volunteers shall comp seclusion, physical re and shall not use the training is completed demonstrated. (c) A pre-requisite for demonstrating compe- training in preventing the need for restrictiv (d) The training shall include measurable for measurable testing (v behavior) on those of methods to determine course. (e) Formal refresher by each service provi annually). (f) Content of the trai provider plans to emp the Division of MH/DI Paragraph (g) of this (g) Acceptable training but are not limited to, (1) refresher in the use of restrictive is (2) guidelines of (understanding immin others); (3) emphasis of rights and dignity of a	direct care to people with atment/habilitation plan terventions, staff including uployees, students or object training in the use of estraint and isolation time-out se interventions until the and competence is r taking this training is betence 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 ining that the service oloy must be approved by D/SAS pursuant to Rule. ng programs shall include, presentation of: formation on alternatives to interventions; on when to intervene hent danger to self and an safety and respect for the all persons involved (using trictive interventions and				

	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C	ONSTRUCTION		E SURVEY IPLETED
		MHL041-837	B. WING		02	2/12/2024
NAME OF PF	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE	, ZIP CODE		
BISBEE P	LACE		SBEE DRIVE SBORO, NC 27407			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN C		(X5)
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE A CROSS-REFERENCED TC DEFICIEI	D THE APPROPRIATE	COMPLETI DATE
V 537	Continued From page	e 6	V 537			
	(4) strategies f	or the safe implementation				
	of restrictive interven	tions;				
		emergency safety				
	interventions which in					
		nitoring of the physical and				
	psychological well-being of the client and the safe					
	use of restraint throughout the duration of the					
	restrictive intervention; (6) probibited procedures:					
	<ul><li>(6) prohibited procedures;</li><li>(7) debriefing strategies, including their</li></ul>					
	importance and purpose; and					
	(8) documentation methods/procedures.					
	(h) Service providers shall maintain					
	documentation of initial and refresher training for					
	at least three years.					
	(1) Documentation shall include:					
		pated in the training and the				
	outcomes (pass/fail);					
		where they attended; and				
	(C) instructor's	name.				
	(2) The Divisio	n of MH/DD/SAS may				
	review/request this de	ocumentation at any time.				
	(i) Instructor Qualific	ation and Training				
	Requirements:					
	. ,	all demonstrate competence				
		esting in a training program				
		reducing and eliminating the				
	need for restrictive in					
		all demonstrate competence				
		esting in a training program eclusion, physical restraint				
	and isolation time-ou					
		all demonstrate competence				
	. ,	grade on testing in an				
	instructor training pro					
	(4) The training					
		nclude measurable learning				
		ble testing (written and by				
		ior) on those objectives and				
						1

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	MHL041-837					
		1	B. WING		02	2/12/2024
NAME OF PF	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE, Z S <b>BEE DRIVE</b>	IP CODE		
BISBEE P	LACE		SBORO, NC 27407			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLETI DATE
V 537	Continued From page	e 7	V 537			
	failing the course.(5)The contentservice provider plansapproved by the Divisionto Subparagraph (j)(6)(6)Acceptableshall include, but notof:(A)understandi(B)methods forcourse;(C)evaluation of(D)documentati(7)Trainers shallannually and demonstof seclusion, physicalltime-out, as specifiedRule.(8)Trainers shallcoach.(10)Trainers shalluse of restrictive interannually.(11)Trainers shallinstructor training at le(k)Service providers	sion of MH/DD/SAS pursuant b) of this Rule. instructor training programs be limited to, presentation ng the adult learner; r teaching content of the of trainee performance; and ion procedures. all be retrained at least strate competence in the use I restraint and isolation I in Paragraph (a) of this all be currently trained in all have coached experience f restrictive interventions at a positive review by the all teach a program on the rventions at least once all complete a refresher east every two years.				
	(Á) who particip outcome (pass/fail);	tion shall include: hated in the training and the where they attended; and				

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STATEMENT	of Health Service Regu T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED		
		MHL041-837	B. WING		02	2/12/2024		
NAME OF P	AME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
BISBEE P		4839 BI	SBEE DRIVE					
	LAGE	GREEN	SBORO, NC 27407					
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLETI DATE		
V 537	Continued From page	e 8	V 537					
	<ul> <li>(I) Qualifications of Q</li> <li>(1) Coaches sl</li> <li>requirements as a tra</li> <li>(2) Coaches sl</li> <li>times, the course wh</li> <li>(3) Coaches sl</li> </ul>	hall meet all preparation ainer. hall teach at least three ich is being coached. hall demonstrate oletion of coaching or uction. shall be the same						
	facility failed to ensur seclusion, physical re time-out on an annua	as evidenced by: iews and interviews, the re staff were trained in estraint, and isolation al basis affecting 1 of 6 ensed Professional (LP)).						
	-A hire date of 12/18/ -A job description of -An expired certificat	LP e dated 4/30/22 to 4/30/23 g in seclusion, physical						
vision of Hea	-Usually all of her tra -"To be honest with y hospital previously al Telehealth position a training for the the gr Director/Associate Pl training would be sch	with the LP revealed: inings were up to date you, I was working for a nd my current position is a nd I did not think about my roup home. He (Executive rofessional (ED/AP)) said the neduled for the end of the						

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			
		MHL041-837	B. WING		02	2/12/2024
AME OF PI	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE	, ZIP CODE		
ISBEE P	LACE		SBEE DRIVE SBORO, NC 27407			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE
V 537	Continued From page	e 9	V 537			
	month."					
	-Was responsible for training in seclusion, isolation time-out -Stated the LP's train April 30th, 2023. -"I just got off the pho sure she attends the	with the ED/AP revealed: ensuring all facility staff had physical restraint, and ing certificate expired on one with her and I will make training scheduled at the oth when the other staffs'				