August 2, 2024

Consultant I
sure & Certification Section
th Services Regulations

1800 Umstead Drive, Williams Building 2718 Mail Service Center Raleigh, NC 27699-2718

Office: 919-855-3831 Fax: 919-715-8078

RE: Plan of Correction for Annual Survey Completed July 22, 2024

Skyywell Health Inc., 1033 Hazelmist Drive, Wake Forest, NC 27587

MHL # 092-994

E-mail Address; skyywellhealthservices@gmail.com

Dear Kimberly Thigpen and Brandi Kimball

Skyywell Health Inc. appreciate the courtesy extended by you while surveying the 1033 Hazelmist Drive Wake Forest, NC 27587

As indicated on the Plan of Correction, we will have the standard level Deficiencies corrected before September 20, 2024

We are committed to providing the highest possible care for the people we serve at Skyywell Health Inc.

If you have questions, do not hesitate to make contact

Sincerely,

Lisa Braswell, Director Skyywell Health Inc. 1033 Hazelmist Drive Wake Forest, NC 27587

MHL # 092-994

E-mail Address: skyvwellhealthservices@gmail.com

Phone 984.292.4515

Division of Health Service Regulation STATEMENT OF DEFICIENCIES AND PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING MHL092-994 07/22/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1033 HAZELMIST DRIVE SKYYWELL HEALTH INC WAKE FOREST, NC 27587 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES 10 PROVIDER'S PLAN OF CORRECTION (X5). COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEPICIENCY TAG REGULATORY OR LSC IDENTITYING INFORMATION) V 000 V 000 INITIAL COMMENTS An annual survey was completed on 7/22/24. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .1700 Residential Treatment Staff Secure for Children or Adolescents. The facility is licensed for 3 and currently has a census of 2. The survey sample consisted of audits of 2 current clients. V 118 V 118 This deficiency will be corrected by the following actions: 27G .0209 (C) Medication Requirements A. All staff will be re-in serviced on 10A NCAC 27G .0209 MEDICATION medication procedures and protocol. REQUIREMENTS All medication will have the proper (c) Medication administration: documentation for administering Prescription or non-prescription drugs shall Health care professional RN will only be administered to a client on the written order of reviewed all orders a person authorized by law to prescribe drugs. D. Health care professional RN will Medications shall be self-administered by review all MAR for accuracy effects only when authorized in writing by the client's E. All medication will be dispense to physician. right person, right dose, right time, Medications, including injections, shall be right route, right dose and right administered only by licensed persons, or by documentation. unlicensed persons trained by a registered nurse, F. RN will be called with any new pharmacist or other legally qualified person and orders, staff will follow all protocols of privileged to prepare and administer medications. (4) adding/discontinuing medication A Medication Administration Record (MAR) of all from the MAR drugs administered to each client must be kept current. G. If a person is discharged from Medications administered shall be recorded hospital a MR2/FL2 will be added to Inhediately after administration. The MAR is to the MAR. All med orders will be include the following: reviewed by RN to ensure accuracy. (C) client's name; H. Management will monitor monthly (D) name, strength, and quantity of the drug; (E) instructions for administering the drug; date and time the drug is administered; and

Division of Health Service Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE/S SIGNATORY

name or initials of person administering the

(X6) DATE

	OF HEATTH SERVICE RES FOR DEFICIENCIES AND DERECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE S COMPLE	
		MHL092-994	B. WING		07/2	2/2024
NAME OF	PROVIDER OR SUPPLIER	STREET AC	DRESS, CITY, S	TATE, ZIP CODE		
		. 1033 HAZELMIST DRIVE WAKE FO	SKYYWI DREST, NC 2	ELL HEALTH INC 7587		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (BACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE APPROPR	HOULD BE	(X5) COMPLETE DATE
V 118	Continued From pag	e I drug.	V 118			
	shall be recorded and	r medication changes or checks kept with the MAR file followed consultation with a physician.			,	
	failed to ensure 2 of	as evidenced by: ew and interview the facility 2 clients' (#1 and #2) medications in the written order of a physician.				
	-Admitted: 2/9/24 -Age: 15 years -Diagnoses: Opposit	of Client #1's record revealed: ional Defiant Disorder, peractivity Disorder (ADHD), Disorder (PTSD)				-
	-No physician's order Review on 7/9/24 or 2024 MARs reveale documented as havi -Amphetamine/dext	f Client #1's May, June, and July d the following medications were ng been administered: roamphetamine 30 mg et by mouth at 8am (ADHD)				
	-Amphetamine/dext tablet by mouth at 8 HCl (hydrochloride (PTSD) 6/10/24-7/4	roamphetamine salts 10 mg 1 am from 5/10/24-7/9/24 -Sertraline 25 mg 1 tablet by mouth at 8pm				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	AND THE PROPERTY AND PARTY AND ADDRESS.	(X2) MULTIPLE CONSTRUCTION A. BUILDING:	(X3) DATE SURVEY COMPLETED

	of Health Service Re	MHL092-994	B. WING		07/2	2/2024
NÁMEOF	PROVIDER OR SUPPLIER	Office of the second	DDD Bog Com	STATE OF BOARD	1 0772	W WOT
		and the second of the second o		STATE, ZIP CODE		
		1033 HAZELMIST DRIV WAKE FO	OREST, NC 2	LL HEALTH INC 17587		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES FMUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIATE D	BE	(XS) COMPLETE DATE
V 118	Continued From page	2	V 118			
-	-Admitted: 6/14/23	of Client #2's record revealed:				
	-Age: 14 years -Diagnoses: ADHD,	Trauma and Stress Related				
	Disorder, Disruptive Disorder, Depressive physician's orders pre	Disorder, Conduct Disorder -No				
	Review on 7/9/24 of	Client #2's May, June, and July				
	2024 MARs revealed documented as having	the following medications were gbeen administered:				
-	(Depressive Disorder	1 tablet by mouth at 6:30pm) from 5/1/24-7/8/24 1 tablet by mouth at 6:30pm	-			
* : .*	(mood) from 5/1/24-7	1/8/24				
	reported:	7/9/24 the facility's Pharmacist			Ì	,
	pharmacy from the ps	escriptions were sent to the yechiatrist's office electronically physician's orders for Client #1				
	dated 7/2/24 including -Amphetamine	g: /dextroamphetamine 30 mg				
	-Sertraline HCl 5	extroamphetamine salts 10 mg 0 mg nysician's orders for Client #2	WWW.Addison.			
		ng: -Lamotrigine 150 mg				
	-Physicians were caut	ious about giving paper orders tion due to concerns with fraud	Photo description			
73 W A		1/9/24 the Licensce reported: continent on 7/2/24 and his	AND THE PROPERTY OF THE PROPER			
			vessmoothiness (944)		Т	,

PLAN OF CORRECTION LIDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING:	(X3) DATE SURVEY COMPLETED					
	MHL092-994	B. WING	07/22/2024					
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE								
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Division of Health Service Regulation

	1033 HAZELMIST DRIV WAKE FO	E SKYYWE DREST, NC 2		
X4) ID REFIX TAG	SUMMARY STATEMENT OF DEPICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REQULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 118		V 118		
	Continued From page 3			
	scrtraline dosage was increased			
	-Client #1 and #2 attended virtual appointments -Client			
	#1 and #2's psychiatrist's office had not given the			
- [facility the physician's orders at time of visit			
	-She had requested physician's orders but the			
	psychiatrist sent electronic orders to the pharmacy			:
V 295		V 295	Voor	
. 2/3		V 293	V295	1
İ	27G .1703 Residential Tx. Child/Adol - Req. for A		This deficiency will be corrected by the following actions:	
	P		Tollowing actions.	
	(LOA NCAC 27G .1703 REQUIREMENTS FOR	,		-
	ASSOCIATE PROFESSIONALS	-		
- 1	In addition to the qualified professional			
	specified in Rule .1702 of this Section, each facility		· .	
	shall have at least one full-time direct care staff who			
- 1	(beets or exceeds the requirements of an associate	1.1		
	professional as set forth in 10A NCAC 27G .0104(1).			; ;
	The governing body responsible for each			· ·
	facility shall develop and implement written policies			
- 1	that specify the responsibilities of its associate professional(s). At a minimum these policies shall	And a		
	address the following:			
	(2) management of the day to day day-to-day			
	operations of the facility;			
	supervision of paraprofessionals regarding		the state of the s	
	(8) ponsibilities related to the implementation of each			
	child or adolescent's treatment plan; and	-		
	participation in service planning meetings.			
	This made is not one and and it	-		
	This Rule is not met as evidenced by:		•	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED
	MHL092-994	B. WING		07/22/2024
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STATE, ZIP CODE		:
SKYYWELL HEALTH INC	1033 HAZI			
	WAKE FO			

(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION	(75)
DAT	REGULATORY OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLET DATE
V 295				
, ¥ 2 ,73	Continued From page 4	V 295	V295	09.20.20
	Based on record review and interview, the facility		This deficiency will be corrected by the following actions:	4
	failed to maintain employment of an Associate Professional (AP) who provided services to the group home on a full-time basis. The findings are:		A. The organization shall be in compliance with all requirements of staffing.	
			 B. The organization will employee an 	
	Review of facility records on 7/9/24 revealed: -No employee record for an AP		Associate Qualified Professional (AQP)in addition to the Qualified Professional	
·	During interview on 7/9/24 the Licensee reported: -The facility had not had an AP since January 2024		C. The AQP will be credentials and management the day-to-day	
	-Had a hard time finding an AP		operations of organizations D. AQP will meet all the educational	
	-Had the position posted on a job posting site -Was planning to repost to other sites -Would try to get credentialed as an AP	AMPLE TO THE PERSON NAMED IN THE PERSON NAMED	background expectations. E. AQP will be trained and monitored by Qualified Professional	
V 296	27G .1704 Residential Tx. Child/Adol - Min. Staffing	V 296		
	(POA NCAC 27G 1704 MINIMUM STAFFING REQUIREMENTS			
	A qualified professional shall be available by telephone or page. A direct care staff shall be able to			
	reach the facility within 30 minutes at all times. The minimum number of direct care staff	ALAMA MININA MANAGAMA		
	required when children or adolescents are present and awake is as follows:	-		
:	(1) two direct care staff shall be present for one.			1
	two, three or four children or adolescents; (2) three direct care staff shall be present for five, six,	-		
	seven or eight children or adolescents; and (3) four direct care staff shall be present for			
	nine, ten, eleven or twelve children or adolescents. (c) The minimum number of direct care staff during			
-	child or adolescent sleep hours is as			

1 PLAN OF CORRECTION IDENTIFICATION NUMBER 1		(X2) MULTIPL A. BUILDING	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED			
	MHL092-994	B. WING			07/22/2024			
NAME OF PROVIDER OR SUPPLIER	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
SKYYWELL HEALTH INC		ELMIST DRI						
	WARE FO	DREST, NC 2	7587		·			
PREFIX (BACR DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A) CROSS-REFERENCED TO THE A	CITON SHOULD	BE COMPLETE			

Division of Health Service Regulation

			 -			
V 296	Continued From page 5 follows:	V 296				
	(1) two direct care staff shall be present and one		٠.	1		
	shall be awake for one through four children or			1		
	adolescents:	٠.		A	۸.	
	(2) two direct care staff shall be present and both					
	shall be awake for five through eight children or		-	4		
÷	adolescents; and			E	3.	
	(3) three direct care staff shall be present of			all and		
	which two shall be awake and the third may be asleep			-		
	for nine, ten, eleven or twelve children or adolescents.					
	(d) In addition to the minimum number of direct					
	care staff set forth in Paragraphs (a)-(c) of this Rule,			C	2.	
	more direct care staff shall be required in the facility	·.				
	based on the child or adolescent's individual needs as		415	D).	
[specified in the treatment plan.					09.20.2024
	(e) Each facility shall be responsible for ensuring					03.20.2024
·	supervision of children or adolescents when they are					
	away from the facility in accordance with the child or					
	adolescent's individual strengths and needs as		÷			
	specified in the treatment plan.					·
	apoonted in the treatment plan.		•	-		
		•	5 4. 2 4.5			
-				V296		
[deficiency will be corrected by the	
				follow	ving actions:	
				TOHOW	The organization shall be in	
			7.0		compliance with all requirements	
					of staffing.	
		٠.		٠	The organization will ensue that	
· į	This Rule is not met as evidenced by:				the client to staff ratio is in	
	Based on record review and interview the facility				compliance with the minimal	
	failed to ensure the minimum number of direct care				number of staff needs identified on	1
	staff was present. The findings are:				person centered plan.	i
					Staff will meet all the educational	
	Review on 7/9/24 of Client #1's record revealed:			٠.	background expectations.	
	-Admitted: 2/9/24		. !		Staff will be trained and monitored	
	-Age: 15 years				by Associate Qualified	
	-Diagnoses: Oppositional Defiant Disorder,		Ì		Professional/ Qualified	
					Professional, monthly supervision	
			. :			
			!			
			- 1			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:		(X3) DATE SU COMPLET		
		MHL092-994	B. WING		07/22/	2024
	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1033 HAZELMIST DRIVE SKYYWELL HEALTH INC WAKE FOREST, NC 27587					
(X4) ID PREFIX TAG	(BACH DEFICIENCY	VIEMENT OF DEFICIENCIES I MUST BE PRECHDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (BACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIATE DI	BB	(X5) COMPLETE DATE
V 296	Continued From page	:6	V 296			

DIVISIO	il of Health Service Regulation						FORM APPROVED
	Attention Deficit Hyperactivity Disorder, Posttraumatic Stress Disorder						
	No description of the descriptio					. *	
	-No documentation that addressed the need for						
	transportation with one staff	l					
			.				
	Review on 7/9/24 of Client #2's record revealed:		. [
	-Admitted: 6/14/23	Ì					
	-Age: 14 years					••	
	-Diagnoses: ADHD, Trauma and Stress Related						
	Disorder, Disruptive Mood Dysregulation						
1	Disorder, Depressive Disorder, Conduct Disorder		1				
7	Product Disorder, Conduct Disorder					•	
	During interview on 7/9/24 Client #1 reported: -						
	"Sometimes" there was only one staff at the facility on					4.0	
	first shift					4 .	
	-Since the end of the school year, had attended an						
1000	internal in Manday, Waland attended an	i					
٠.	internship Monday, Wednesday, Thursday and Friday		and the second		•		
	of each week from 9:30am to 1:30pm			4.5			
	-One staff would transport him to his internship on						
·	those days	6					
	-When he arrived at the facility from his internship at						
	1:30pm, only one start was present at the facility with					•	
	Client #2		1.			4	
	-A second staff came in after 1:30pm after he arrived at						
	the facility					**	
:]							
	During interview on 7/9/24 Client #2 reported: -There		· Í				
	was only one staff at the facility when Client #1 was at						
	his internship several days during first shift		Sp. 5				
	-A second staff came in 1:00pm after client #1 arrived						
1	at the facility			- '			
	-"That's every week."					•	
	-Only on certain days are two staff present in the						
	facility, "not always two staff working."		Ĩ				
	Victoria de la constanta de la			:			· .]
	During interview on 7/9/24 the Licensce reported: -		-				
	Always have two staff available	1		. 1			
	-Lived near the facility and could make it to the facility					**	
	quickly						
	чиных						
			ŀ			4.3	
				 			
							* .

STATEMEN PLAN OF C	ORRECTION (X1) PROVIDER/SUPPLIF ORRECTION IDENTIFICATION NUMBER:	TER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE : COMPL	
	MHL092-994		B. WING		<u> </u>	07/2	2/2024
	ELL HEALTH INC	3 HAZE	dress, city, s LMIST DRI REST, NC 2				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRE	S PLAN OF CORRECTION SHOULD TO THE APPROPRIATE D	IRE .	(XS) COMPLETE DATE
V 296	Continued From page 7 -When only one client was at the facility, there w	as	V 296				
Division of U	notes Caustan Daniel 1						

	only one sign postogulation					3PPKO1
	-One staff would take Client #1 to his internship					
	several days a week, and one would stay at the facility		The second secon	•		
	with Client #2	,				
-	-Staff took Client #1 to his internship and "may run	÷				
	errands, but comes back"	1				*,
	crianus, our comes back"			*		
		Í	İ			
V 536		37.53.6			•	
		V 536	V536	-	-	
	27E 0107 01 701 14 - 67 3	1	This deficiency will b	e corrected h	y the	
	27E .0107 Client Rights - Training on Alt to Rest. Int.	.	following actions:		7 410	
			and a decision.			
·	10A NCAC 27E .0107 TRAINING ON					
	ALTERNATIVES TO RESTRICTIVE			÷*		
	INTERVENTIONS	1				
	Facilities shall implement policies and		- A			
- ·	fractices that emphasize the use of alternatives to					
	restrictive interventions.					
	Prior to providing services to people with		the state of the s			
	disabilities, staff including service providers,	1 .				
	employees, students or volunteers, shall demonstrate					
	competence by successfully completely					
-	competence by successfully completing training in			A		
i	communication skills and other strategies for creating				V	
	an environment in which the likelihood of imminent					
- A. }	(tanger of abuse or injury to a person with disabilities					
	or others or property damage is prevented.			:		
- 1	Provider agencies shall establish training		·		the safe of the sa	
	based on state competencies, monitor for internal		•	* * * * * * * * * * * * * * * * * * * *	1.	
.	formuliance and demonstrate the second design of th					
	(d)mpliance and demonstrate they acted on data		-		. [
	gathered.					
	The training shall be competency-based,					
- i	include measurable learning objectives, measurable	i i i i i i i i i i i i i i i i i i i				
t	testing (written and by observation of behavior) on					
- A. 1	(hose objectives and measurable methods to determine					
	passing or failing the course.		•			
] '	Formal activation to the course.					
	Formal refresher training must be completed					
[]	by each service provider periodically (minimum		•	•		-
1	annually).				•	
		<u> </u>				``
				<u> </u>		
MENT	OF DEFICIENCIES AND (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION		(X3) DATE SUR	VEV
UT CUN	RECTION IDENTIFICATION NUMBER:	A. BUILDING:		.* .	COMPLETE	
	<u> </u>	B. WING	•			
	MHL092-994				07/22/2	024

SKYYWELL HEALTH INC

		REST, NC 2	?758 7	1.5
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 536	Continued From page 8	V 536		
an annual and an annual and an an an an an an an an an an an an an	(f) Content of the training that the service provider wishes to employ must be approved by the Division of MH/DD/SAS pursuant to Paragraph (g) of	and the same of th		
		AMERICA DE CONTRACTO		

DIVIS	ion offisicado, Service I				FORM APPROVED
	(g) Staff shall	demonstrate competence in the			
•	following core are:	38:			
1	(1) knowledge	and understanding of the people			
	being served;	8 v. me people		. 1	
		g and interpreting human behavio	To a second seco		
	(3) recognizin	g the effect of internal and externa	r;		
	cirecente that man	g the effect of internal and externa	ป	1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 -	
	(4)	affect people with disabilities;			
	(4) strategies	or building positive relationships			
	with persons with c	lisabilities:			
	(5) recognizin	g cultural, environmental and		<u>.</u>	
1	organizational facto	ors that may affect people with			
	disabilities;	- Propie			
	(6) recognizin	g the importance of and assisting i			
	the person's involve	ement in making decisions about	n .	4	
	their life;	ment in maxing decisions about			
				,	
	(7) SKUIS IN US	sessing individual risk for			
	escalating behavior				
	(8) communica	tion strategies for defusing and de	; -		
	escalating potential	y dangerous behavior: and		•,	
100	(9) positive be	navioral supports (providing mean	e		
	for people with disa	bilities to choose activities which			
	directly oppose or n	eplace behaviors which are unsafe			
	(h) Service provide	rs shall maintain documentation o	성 -	v. Ve	
	initial and reference	is shan maintain documentation o	f		
	(1) Document	training for at least three years.		the second of	
	(1) Document	ation shall include:			
	(A) who partici	pated in the training and the			
	outcomes (pass/fail)			•	
•	(B) when and w	here they attended; and			
	(C) instructor's	name;			
4.1		on of MH/DD/SAS may			
		or the state of th			
	NT OF DEFICIENCIES AND	(X1) PROVIDER/SUPPLIER/CLI/	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY
TEMP OF C	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
					
		MHL092-994	B. WING	<u> </u>	
		[WITE 092-954			07/22/2024
NAME OF	PROVIDER OR SUPPLIER	STORETA	DDRESS, CITY, STATE, ZIP CODE		
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/Y/ A) (D)			OREST, NC 27587		
(X4) ID PREFIX	SUMMARY STA	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL		R'S PLAN OF CORRECTION	
TAG	REGULATORY OR L	SCIDENTIFYING INFORMATION)	PREFIX TAG (EACH CORR	ECTIVE ACTION SHOULD	BE COMPLETE
<u> </u>			CACAG-REFERENCED	TO THE APPROPRIATE DE	PICIENCY) DATE
37.53.5	A				
V 536	F-6	9 review/request this	V 536		
	documentation at any	time. (i) Instructor	la de la la la la la la la la la la la la la		
	Qualifications and To	aining Requirements:			
	(1) Trainers shall	I demonstrate competence by			
	COOPERS LEVICE on took	morale a training personal simulation	1		
	scoring 100% on test	ng in a training program aimed at			1

DIVISIO	deandaline sunderen				LOKW APPROVED
	(2) Trainers sh	all demonstrate competence by			
	scoring a passing gr	rade on testing in an instructor	The state of the s		
	training program.	THE PROPERTY OF THE PARTY OF TH	Permanent		
	(3) The trainin	g shall be			ľ.
	competency-based.	include measurable learning			
	objectives, measura	ble testing (written and by			* *
	observation of beha	vior) on those objectives and			
	measurable methods	s to determine passing or failing the	- Landing	.* ÷,	
	course.	s to determine bassing of family the	2		
		of the instructor training the			
	Sérvice provider pla	ns to employ shall be approved by			.
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	the Division of MH	DD/SAS pursuant to			
	Subparagraph (i)(5)	of this Bula	No. of the last of	* * *	4.
: .	(5) Accentable	or ans reme.			
	itichide but are not li	instructor training programs shall imited to presentation of:	- The state of the		
	(A) understand	ling the adult learner; (B)			
		g content of the course;			
*	(C) methods for	evaluating trainee performance;	1100		
	and	evaluating trainee performance;		*	
	- 1 1 E	on procedures.			
		Il have coached experience		; " ¹	14) H
	teaching a training of	rogram aimed at preventing,		7 7- 1	
	reducing and eliming	ating the need for restrictive			**
	interventions at least	one time, with positive review by			
	the coach.	one time, with positive review by			
		Il teach a training program aimed			
	at preventing reduci	ng and eliminating the need for		W - 1 - 1	1.1
	restrictive intervention	ons at least once annually.			
	(8) Trainers sha	Il complete a refresher instructor			
	training at least every	/ two years			1 1
		, 5.75			
			To page 1		
	OF DEFICIENCIES AND	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION	(X3)	DATE SURVEY
PLAN OF CO	KREUTION	IDENTIFICATION NUMBER:	A DISERBONG		COMPLETED

A (X2) MULTIPLE CONSTRUCTION A. BUILDING:	(X3) DATE SURVEY COMPLETED
B. WING	07/22/2024
PREFIX TAG (EACH CORRECTIVE ACTIO	ON SHOULD BE COMPLETE
V 536	
	A. BUILDING: B. WING DDRESS, CITY, STATE, ZIP CODE ZELMIST DRIVE OREST, NC 27587 ID PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO THE APPRI V 536

LIVIOL			FORM APPROVED
	(2) The Division of MH/DD/SAS may request		
	and review this documentation any time		
	(k) Qualifications of Coaches:		
	(1) Coaches shall meet all preparation		
	requirements as a trainer.		
	(2) Coaches shall teach at least three times the		
	course which is being coached.		
	(3) Coaches shall demonstrate composence by		
	completion of coaching or train-the-trainer instruction.		
	(1) Documentation shall be the same preparation as for trainers.		
1.5	uaniers.		
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		The state of the s	
100			
100			
	This Rule is not met as evidenced by:		
	Based on record review and interview the facility		
	failed to ensure one of three audited staff (#1) was		
	trained in alternatives to restrictive interventions. The		
	findings are:		

	Review on 7/9/24 of staff #1's record revealed:		
	-Hire date of 1/3/23		
	-Job title - Paraprofessional		
.	-No evidence of alternatives to restrictive interventions		
	training.		
	training,		
STATEMENT	OF DEFICIENCIES AND (XI) PROVIDER/SUPPLIER/CLIA		
PLAN OF CO	OF DEFICIENCIES AND (XI) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY

STATEMEN PLAN OF C	IT OF DEFICIENCIES AND ORRECTION	(XI) PROVIDER/SUPPLIER/CLI/ IDENTIFICATION NUMBER:	A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		MHL092-994	B. WING		07/22/2024
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE	Tabalata
	ELL HEALTH INC	WAKE F	CELMIST DRI		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	JEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL IC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIATE D	BE COMPLETE
V 536	Continued From page Interview on 7/9/24 st	aff#1 stated:	V 536	V536 This deficiency will be corrected by following actions:	op.20.202 4
	few weeksWas home from colle with her mother (Lice training in alternatives -"Thought" a training	orking in the facility for the last age for the summer and worked used on shiftsDid not have to restrictive intervention, for alternatives to restrictive aduled in the next few weeks.		A. The organization shall be a compliance with all require of staffing training. B. All staff will be trained on Alternative Restrictive Interventions	ments
Division of He	esith Service Reculation			 C. Staff will be trained prior to providing services. 	

STATE FORM

07/25/2024 FORM APPROVED

Division of Minath Service Riggintons/2/24 and would only work when home on school breaks. Staff will show competency in the proper use of and alternatives to Interview on 7/9/24 the Licensee stated: these procedures. -Used Crisis Prevention Institute (CPI) for their E. Staff will be trained annually or as alternatives to restrictive intervention training. need to ensure the organization -Staff #1 was her daughter who was home from remain compliant. college for the summer and worked on shift with her. Management will monitor -Staff#1 had been working for a few weeks, -Staff monthly #1's hire date was written down when she first put her records together to open the facility, but had not worked until recently. -Staff #1 had not received training in CPI prior to working with the clients. -Scheduled staff #1 a CPI training for next week. V 537 27E .0108 Client Rights - Training in Sec Rest & ITO 10A NCAC 27E .0108 TRAINING IN SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT (a) Seclusion, physical restraint and isolation time-out may be employed only by staff who have been trained and have demonstrated competence in the proper use of and alternatives to these procedures. Facilities shall ensure that

STATEME PLAN OF C	NT OF DEFICIENCIES AND CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL		(X3) DATE SURVEY COMPLETED
		МНL092-994	B. WING		07/22/2024
NAME O	F PROVIDER OR SUPPLIER	1033 HAZELMIST DRIVE		TATE, ZIP CODE ELL HEALTH INC 17587	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (BACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRIATE DEF	(X3) COMPLETE FICIENCY) DATE
V 537	staff authorized to en procedures are retrain competence at least a (b) Prior to providisabilities whose tre restrictive intervention providers, employees complete training in the restraint and isolation interventions until the competence is demon	aploy and terminate these ned and have demonstrated natually. iding direct care to people with atment/habilitation plan includes as, staff including service, students or volunteers shall he use of seclusion, physical time-out and shall not use these training is completed and	V 537	V537 This deficiency will be corrected by the following actions: A. The organization shall be in compliance with all training requirements B. All staff will be trained on Alternative Restrictive Interventions C. Staff will be trained prior to providing services. D. Management will have proposed documentation to ensure every of training. E. Staff will show competency in the services of training.	er idence

CHARLET AND COMPETENCE BY COMPLETION of training			ALLKO ARD
in preventing, reducing and eliminating the need for restrictive interventions. (d) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determin passing or failing the course. (e) Formal refresher training must be completed by each service provider periodically (minimum	e G. Sta	roper use of and alternatives to ese procedures. taff will be trained annually or as eed to ensure the organization main compliant. taff will not be schedule to work thout completing all trainings anagement will monitor monthly.	
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 us of restrictive interventions;			
(2) guidelines on when to intervene (understanding imminent danger to self and others); (3) emphasis on safety and respect for the rights and dignity of all persons involved (using concepts of least restrictive interventions and			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(XI) PROVIDER SUPPLIER CLIA IDENTIFICATION NUMBER: MHL092-994	(X2) MULTIPI A. BUILDING B. WING	LE CONSTRUCTION	(X3) DATE COMPL	
NAME OF PROVIDER OR SUPPLIES	1033 HAZELMIST DRIV		STATE, ZIP CODE ELL HEALTH INC 17587		
PREFIX (EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE APPRO	N SHOULD BE	(X5) COMPLETE DATE
restrictive interven (5) the use of which include cont of the physical and client and the safe i duration of the rest (6) prohibited (7) debriefing importance and pur (8) documenta Service providers s initial and refresher	n an intervention); for the safe implementation of tions; emergency safety interventions inuous assessment and monitoring psychological well-being of the use of restraint throughout the rictive intervention; procedures; strategies, including their	V 537			

lealth Sarvier Riggued in the training and the		FORM APPROV
comes (pass/fail);		
when and where they attended; and (C)		
ructor's name.		
The Division of MH/DD/SAS may		
ew/request this documentation at any time (i)		
ructor Qualification and Training Requirements		
Trainers shall demonstrate commetence by		
ing 100% on testing in a training program aimed		
reventing, reducing and eliminating the need for		
notive interventions.		
Trainers shall demonstrate competence by		
ing 100% on testing in a training program		
hing the use of seclusion, physical restraint and		
tion time-out	of contract of the contract of	
Trainers shall demonstrate competence by		
ing a passing grade on testing in an instructor		
ing program. (4) The training shall be		
petency-based, include measurable learning		
nives, measurable testing (written and by	i de	
	and the same of th	
		# 15 P
	when and where they attended; and (C) ructor's name. The Division of MH/DD/SAS may ew/request this documentation at any time. (i) ructor Qualification and Training Requirements: Trainers shall demonstrate competence by ing 100% on testing in a training program aimed eventing, reducing and eliminating the need for ictive interventions.	when and where they attended; and (C) ructor's name. The Division of MH/DD/SAS may ew/request this documentation at any time. (i) ructor Qualification and Training Requirements: Trainers shall demonstrate competence by ing 100% on testing in a training program aimed eventing, reducing and eliminating the need for ictive interventions. Trainers shall demonstrate competence by ing 100% on testing in a training program ning the use of seclusion, physical restraint and tion time-out. Trainers shall demonstrate competence by ing a passing grade on testing in an instructor ing program. (4) The training shall be bettency-based, include measurable learning

STATEMEN	NT OF DEFICIENCIES AND	(XI) PROVIDER/SUPPLIER/CLIA	(Y2) M (3.70)	LE CONSTRUCTION	
PLAN OF (CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		(X3) DATE SURVEY COMPLETED
			A. BOILDING		00.11.00
		MHL092-994	B. WING		
		174111.00/74-77-4			07/22/2024
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	STATE, ZIP CODE	
		1033 HAZELMIST DRIV			$x = x^{-1}$
		WAKE FO	DREST, NC 2	27587	
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRE	Alman (
PREFIX TAG	(EACH DEFICIENCY REGULATORY OR 13	MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SH	OULD BUT COMPLETE
V 537	The state of the s			CROSS-REFERENCED TO THE APPROPRIA	ATE DEFICIENCY) DATE
V 037	Continued From page		V 537	and the second s	
	observation of behavi	ior) on those objectives and		C. C. C. C. C. C. C. C. C. C. C. C. C. C	
	measurable methods t	to determine passing or failing the			
٠	course.				
	(5) The content (of the instructor training the			
	service provider plans	s to employ shall be approved by			
	the Division of MH/D	D/SAS pursuant to	· V		
$v = \{v^{(k)}\}$	Subparagraph (j)(6) o				
	(6) Acceptable in	istructor training programs shall			
	include, but not be lin	nited to, presentation of:		4	
	(A) understandir	ng the adult learner; (B)			
	(C) evaluation of	content of the course;			
	(C) evaluation (of trainee performance; and (D)			
	documentation proced (7) Trainers shall	he material at least and the			
	and demonstrate com-	be retrained at least annually petence in the use of seclusion,			
	nhysical restraint and	isolation time-out, as specified in			
,	Paragraph (a) of this P	bile			
	(8) Trainers shall	be currently trained in			
	CPR.	The state of the s			

Division	69 Health Seinere stratulation oached experience in		FURM APPROVED
	teaching the use of restrictive interventions at least two		
	times with a positive review by the coach		
	(10) Trainers shall teach a program on the use of	a 1	
1	restrictive interventions at least once annually		
1	(11) Trainers shall complete a refresher instructor		
	training at least every two years, (k) Service providere		
	shall maintain documentation of initial and refresher		
	instructor training for at least three years		
	(1) Documentation shall include:		
	(A) who participated in the training and the		
	outcome (pass/fail);		
	(B) when and where they attended; and (C)		
	instructor's name.		
	网络沙丘 人名英格兰人 医神经性 人名英格兰 医结束性 海豚		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL092-994	(X2) MULTIPI A. BUILDING B. WING	LE CONSTRUCTION	СОМІ	E SURVEY PLETED
NAME OF PROVIDER OR SUPPLIER	STREET AT 1033 HAZELMIST DRIVE		STATE, ZIP CODE ELL HEALTH INC 27587		/22/2024
PREFIX (EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECIDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPROPRIAT	MILD RE	(X5) COMPLETE DATE
review/request this d (I) Qualifications of (I) Coaches sha requirements as a tra (2) Coaches sha course which is being shall demonstrate con coaching or train-the (m) Documentation for trainers. This Rule is not met Based on record revie failed to ensure one of	on of MH/DD/SAS may locumentation at any time. Coaches: all meet all preparation iner. all teach at least three times, the g coached. (3) Coaches impetence by completion of trainer instruction. Shall be the same preparation as	V 537			

Division of Health Service Regulation Review on 7/9/24 of staff #1's record revealed: -Hire date of 1/3/23 -Job title- Paraprofessional -No evidence of restrictive interventions training. Interview on 7/9/24 staff #1 stated: -She had only been working in the facility for the last few weeks. -Was home from college for the summer and worked with her mother (Licensee) on shifts. -Did not have training in restrictive intervention. -"Thought" a training for restrictive interventions was scheduled in the next few weeks. -Will go back to college on 8/2/24 and would only work when home on school breaks.

PLAN OF	NT OF DEFICIENCIES AND CORRECTION	IDENTIFICATION NUMBER: A. BUILDING:			(X3) DATE SURVEY COMPLETED		
NAMEO	NAME OF PROVIDER OR SUPPLIER STREET AD					07/22/2024	
141,650 01	TROVIDER OR SUPPLIER		and the second s	STATE, ZIP CODE			
		1033 HAZELMIST DRIVE WAKE FO	SKYYWI DREST, NC 2	ELL HEALTH INC 17587			,
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED TO THE A	CTION SHOULD	D.C.	(X3) COMPLETE DATE
V 537	Continued From page	16	V 537	The state of the s	TI KOLKLADE DE	PICIBING Y)	DATE
	restrictive intervention -Staff #1 was her dang college for the summe -Staff #1 had been wo #1's hire date was write records together to op worked until recentlyStaff #1 had not receive working with the clienters.	on Institute (CPI) for their in training. In training. In training the was home from and worked on shift with her, rking for a few weeksStaff ten down when she first put her can the facility, but had not wed training in CPI prior to					
V 752	27G .0304(b)(4) Hot v	Vater Temperatures	V 752				· ·
	EQUIPMENT (b) Safety: Each faciliand equipped in a man safety of clients, staff (4) In areas of the	ty shall be designed, constructed ner that ensures the physical and visitors. e facility where clients are the temperature of the water					

PRINTED: 07/25/2024 Division and half material and the state of FORM APPROVED Fahrenheit. This Rule is not met as evidenced by: Based on observation and interview the facility failed to ensure the water temperature was maintained between 100-116 Fahrenheit. The findings are: Observation on 7/9/24 at 10:50 AM revealed: -Kitchen sink water temperature was 94 degrees Fahrenheit -The clients' bathroom sink and shower water temperature was 94 degrees Fahrenheit

STATEMEN PLAN OF C	NT OF DEFICIENCIES AND CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION 3:	(X3) DATE COMPI	
		MHL092-994	B. WING		07/	22/2024
NAME OF	PROVIDER OR SUPPLIER				1 9772	.2/2024
A THILL OF	TROVIDER OR SUFFLIER			STATE, ZIP CODE		
		1033 HAZELMIST DRIVI WAKE FO	E SKYYWI DREST, NC 2	ELL HEALTH INC 27587		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE APPRO	ISHOUTD BE	(XS) COMPLETE DATE
V 752	Continued From page	17	V 752	V752	MATE DEFICIENCY)	294115
			1 1JL	This deficiency will be corre	otad by the	
	Interview on 7/0/24 S	staff #2/Licensee Husband stated:		following actions:	cied by the	
	-He had checked the	water this week and it was a 100		A. The organization wi	ll he in	
	degrees Fahrenheit.	water this week and it was a 100		accordance with the	facility design	
		darly, but noticed it was not		and equipment guid	eline related to	
	getting warm.	many, but noticed it was not		hot water temperatu	ires	
		for their accreditation and doing	* .	B. The organization wi		-
	water temperature che	ecks		the water temperatu	re is with in the	
	-Will turn up the water	r heater and keep a check on the	1	110- 116 degree Fa	hrenheit	
	water temperature.	are the troop it chief on the		protocol.		
				C. Water Temperatures	s will be	
				checked daily at ear	ch receptacle	
				with supporting doc	umentation.	
				 D. Staff will be in service 	e on the	
				protocol of checking	the water	
				temperature.		
				E Staff will be in service		•
				protocol of when to	report and to	
1				whom they should n	port and	
1			į	increase/decrease in	1 the water	•
. [temperature.		
				F. Management will mo	onitor all and	•
	James Barrell			ensure are temperal		
				equipment is operati		
				G. Management will mo	nitor weekly.	
CXT	alth Service Regulation					

Division of Health Service Regulation		PRINTED: 07/25/2024 FORM APPROVED