Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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		MHL066-024	B. WING		09/3	0/2024
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
FAMILY	ADVANTAGE LLC	3104 HW GARYSB	Y 301 N URG, NC 278	B31		
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
V 000	00 INITIAL COMMENTS		V 000			
	completed on Septe complaint was substantial w	ficiencies were cited. sed for the following service C 27G .1700 Residential				
V 132	G.S. 131E-256(G) H Allegations, & Prote		V 132			
	Allegations, & Protection G.S. §131E-256 HEALTH CARE PERSONNEL REGISTRY (g) Health care facilities shall ensure that the Department is notified of all allegations against health care personnel, including injuries of unknown source, which appear to be related to any act listed in subdivision (a)(1) of this section. (which includes: a. Neglect or abuse of a resident in a healthcare facility or a person to whom home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided. b. Misappropriation of the property of a resident in a health care facility, as defined in subsection (b) of this section including places where home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided. c. Misappropriation of the property of a healthcare facility. d. Diversion of drugs belonging to a health care facility or to a patient or client.					

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

(X6) DATE TITLE

Division of Health Service Regulation

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			71. 501251110.		R	
		MHL066-024	B. WING		1	0/2024
NAME OF	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE		
FAMILY A	ADVANTAGE LLC	3104 HWY	′ 301 N JRG, NC 278	331		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON.	(X5)
PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	COMPLETE DATE
V 132	Continued From pa	ge 1	V 132			
	a patient or client for providing services). Facilities must have acts are investigate to protect residents investigation is in prinvestigations must Department within the notification to the D. This Rule is not meased on record refailed to notify Heal (HCPR) of allegation of 3 audited staff (#	e evidence that all alleged and must make every effort from harm while the rogress. The results of all be reported to the five working days of the initial epartment.				
	report dated 5/31/2 "Caller (FC #5) A male at the group the floor for no reas works for the group - "Caller asked the caller wanted to go (advised) that the [sthe subj face and to f*cking around with go outside to cool or grab water and the	f a 911 Communications 4 revealed: is a 13 YOM (year old male). home pushed the caller on son. Male is a [staff #3] and he home." he [staff #3] for water and the outside and the caller adv staff #3] subj (subject) got into old him "Do you think I am you" and the caller wanted to lown and turned back in to [staff #3] subj pushed the d and the caller walked out of om the subj"				

Division of Health Service Regulation STATE FORM

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		MHL066-024	B. WING			R 30/2024
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
FAMILY	ADVANTAGE LLC	3104 HWY GARYSBL	/ 301 N JRG, NC 27	831		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
V 132	- He "had to get - He implemente - FC #5 reported - The police inve "assault on a minor charges" Interview on 8/28/24 (MHC) reported: - "[FC #5] said he give any details" - She didn't notification because she didn't Interview on 9/6/24 reported: - FC #5 "alleged - Believed staff # Interview on 9/30/24 - The MHC was HCPR - Wasn't aware Fassaulted him	ge 2 him out my face" d a "defensive shove" him to the police stigated and concluded an , but they (police) didn't press 4 the Mental Health Counselor e was assaulted, but wouldn't / HCPR of the allegation know she was supposed to the Qualified Professional assault" against staff #3 3 was reported to the HCPR 4 the Licensee reported: responsible for reporting to the FC #5 alleged staff #3 MHC didn't report staff #3 to	V 132			
V 536	27E .0107 Client Ri Int. 10A NCAC 27E .01	ghts - Training on Alt to Rest. 07 TRAINING ON	V 536			
	ALTERNATIVES TO INTERVENTIONS (a) Facilities shall i practices that emph to restrictive interve (b) Prior to providir disabilities, staff incomplete.	O RESTRICTIVE mplement policies and hasize the use of alternatives				

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DIVISION	Division of Health Service Regulation						
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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		MHL066-024	B. WING		1	0/2024	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
		3104 HW)	/ 301 N				
FAMILY ADVANTAGE LLC GARYSB			JRG, NC 27	831			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE	
V 536	Continued From pa	ge 3	V 536				
	demonstrate compecompleting training other strategies for which the likelihood or injury to a persor property damage is (c) Provider agencibased on state comcompliance and derigathered. (d) The training shall include measurable testing behavior) on those methods to determicourse. (e) Formal refreshed by each service proannually). (f) Content of the training training shall refreshed by each service proannually). (g) Staff shall demorphisms of MH/IP Paragraph (g) of this (g) Staff shall demorphisms or areas (1) knowledg people being served (2) recognizing external stressors training training shall training training training served (2) recognizing external stressors training training shall training train	etence by successfully in communication skills and creating an environment in a of imminent danger of abuse in with disabilities or others or prevented. It is shall establish training inpetencies, monitor for internal immonstrate they acted on data at the competency-based, a learning objectives, (written and by observation of objectives and measurable ine passing or failing the certraining must be completed ovider periodically (minimum raining that the service employ must be approved by DD/SAS pursuant to is Rule. In onstrate competence in the size and understanding of the digrand interpreting human and the effect of internal and that may affect people with the for building positive ersons with disabilities; and cultural, environmental and ours that may affect people with					
	(5) recognizir organizational facto disabilities;(6) recognizir	ng cultural, environmental and					

Division of Health Service Regulation

DIVISION	Division of Health Service Regulation						
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED	
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		MHL066-024	D: Wiite		09/3	0/2024	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
		3104 HW	/ 301 N				
FAMILY A	FAMILY ADVANTAGE LLC GARYSE			024			
			JICG, NC 27			I	
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION CONTROL OF THE PROVIDER OF THE P		(X5)	
PREFIX TAG		' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO		COMPLETE DATE	
IAG	TREGOLD TOTAL	oo ibarrii Tiiro iin orani (Tiori)	IAG	DEFICIENCY)			
V 536	Continued From pa	ge 4	V 536				
	-1:-:	to tigo.					
	decisions about the						
		ssessing individual risk for					
	escalating behavior						
		cation strategies for defusing					
	and de-escalating p	otentially dangerous behavior;					
	and						
	(9) positive be	ehavioral supports (providing					
	means for people with disabilities to choose activities which directly oppose or replace behaviors which are unsafe). (h) Service providers shall maintain						
		nitial and refresher training for					
	at least three years						
		tation shall include:					
		ipated in the training and the					
	outcomes (pass/fail						
		I where they attended; and					
	(C) instructor	•					
		ion of MH/DD/SAS may					
		documentation at any time.					
		ications and Training					
	Requirements:						
	` /	shall demonstrate competence					
		testing in a training program					
		g, reducing and eliminating the					
	need for restrictive						
	` '	shall demonstrate competence					
		g grade on testing in an					
	instructor training p						
		ng shall be					
		, include measurable learning					
		able testing (written and by					
		avior) on those objectives and					
		ds to determine passing or					
	failing the course.						
		ent of the instructor training the					
		ins to employ shall be					
		vision of MH/DD/SAS pursuant					
	to Subparagraph (i)						

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STATE FORM 6899 F61011 If continuation sheet 5 of 17

<u>Divisio</u> n	Division of Health Service Regulation						
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		MHL066-024	B. WING		R 09/30/2024		
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY. S	STATE, ZIP CODE	-		
		3104 HWY					
FAIVILY A	ADVANTAGE LLC	GARYSBL	JRG, NC 27	831			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE	
V 536	Continued From pa	ge 5	V 536				
	(5) Acceptable shall include but are (A) understand (B) methods course; (C) methods performance; and (D) document (6) Trainers of teaching a training reducing and elimin interventions at least review by the coach (7) Trainers of aimed at preventing need for restrictive annually. (8) Trainers of instructor training and (j) Service provider documentation of intraining for at least (1) Documentation of intraining for at least (1) Documentation (C) instructor (C) instructor (C) instructor (C) instructor (C) The Division request and review (C) (C) Coaches requirements as a to (C) Coaches the course which is (C) Coaches competence by contrain-the-trainer instructor (C) the trainer instructor (C) Coaches (C) Coa	le instructor training programs e not limited to presentation of: ding the adult learner; for teaching content of the for evaluating trainee ation procedures. Shall have coached experience program aimed at preventing, lating the need for restrictive est one time, with positive in. Shall teach a training program greducing and eliminating the interventions at least once shall complete a refresher t least every two years. It is shall maintain initial and refresher instructor three years. In mentation shall include: Sipated in the training and the lip; I where attended; and I's name. It is documentation any time. If Coaches: Shall meet all preparation trainer. Shall teach at least three times being coached. Shall demonstrate inpletion of coaching or					

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DIVISION	Division of Health Service Regulation					
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
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			B. WING		F	
		MHL066-024	B. WINO		09/3	0/2024
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
		3104 HW		,		
FAMILY	ADVANTAGE LLC			024		
		GARTSB	JRG, NC 27	831		
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO		COMPLETE DATE
IAG	TEGGET TOTAL OTTE	oo ibanii hiito iiti ortiib iiti	IAG	DEFICIENCY)		
V 536	Continued From pa	ge 6	V 536			
	This Rule is not me	et as evidenced by:				
	Based on record re	view and interview, the facility				
		f 3 audited staff (#3)				
		petence in communication				
		ing and de-escalating				
		us behaviors. The findings are:				
	potertially darigore	ao bonavioro. The infamge are.				
	Review on 8/28/24	of staff #3's personnel record				
	revealed:	or stair #0 5 personner record				
	- Hired 1/30/23					
	- Title: Residenti	al Caupaolar				
		tervention Plus (NCI +)				
	Training certificate	dated 2/1/24				
	D : 0/07/04					
		of former client (FC) #5's				
	record revealed:					
	- Admitted 4/12/2	24				
	- Age: 13					
		lajor Depressive Disorder,				
	Oppositional Defiar					
		peractivity Disorder				
		dated 4/4/24: "Family				
		st [FC #5] in expressing				
		ecisions, and encourage him to				
		nt effective coping skills to				
	manage changes ir					
	5 5					
	Review on 9/3/24 o	f a 911 Communications				
	report dated 5/31/2					
		is a 13 YOM (year old male).				
		home pushed the caller on				
	A male at the group	nome pushed the caller off				

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STATE FORM 6899 If continuation sheet 7 of 17 F61011

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		A. BUILDING:			R	
	MHL066-024	B. WING			30/2024	
NAME OF PROVIDER OR SUPPLIE	R STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
FAMILY ADVANTAGE LLC	3104 HW GARYSB	Y 301 N URG, NC 27	B31			
PREFIX (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE	
works for the grou- "Caller asked caller wanted to g (advised) that the the subj face and f*cking around wit go outside to cool grab water and the caller on the grouthe building away. Review on 8/27/2 Improvement Systomater and against a staff directives aggressively chall threats and against	ason. Male is a [staff #3] and he up home." the [staff #3] for water and the o outside and the caller adv [staff #3] subj (subject) got into told him "Do you think I am h you" and the caller wanted to down and turned back in to e [staff #3] subj pushed the nd and the caller walked out of from the subj" 4 of the Incident Response tem (IRIS) revealed: ated 6/3/24: "Client (FC #5) was sive and defiant with no regards at allclient then defiantly and enged staff by shouting, making demanding snacks wile ites directly in staff's face; resonal space; staff used a sing his hands in pushing client 24 staff #3 reported: srupting the facility by stealing up wires in the facility C #5 to do things that would have a "defensive shove" the police restigated and concluded an or, but they (police) didn't pressing "fight or flight" and	V 536				

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STATE FORM 6899 F61011 If continuation sheet 8 of 17

Division of Health Service Regulation

DIVISION	of Health Service Re	egulation				
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
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NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
FAMILY A	ADVANTAGE LLC	3104 HW				
		GARYSBI	JRG, NC 27	831		
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI		COMPLETE DATE
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V 536	Continued From pa	ge 8	V 536			
	FC #5's guardian w	as unsuccessful because FC				
		return any phone calls.				
	-					
		4 the NCI+ Chief Executive				
	Officer/Owner repo					
		echniques involve talking to				
	the client to resolve					
		escalated to aggression then				
		ve moved himself out of the				
	way - Staff should not put hands on the client in that					
		t put nands on the client in that				
	manner					
	Attempted interview	vs on 8/28/24, 8/29/24 &				
		impliance Officer/NCI+				
		ccessful because the				
		/NCI+ Instructor didn't return				
		or to the exit of the survey.				
	,	•				
	Interview on 9/6/24	the Qualified Professional				
	reported:					
		ressive towards staff #3				
		ted to de-escalate the				
	, ,	FC #5 to "step out of his (staff				
	#3) face					
	Interview on 0/30/2	4 the Licensee reported:				
		mented a therapeutic hold" on				
	FC #5	nonced a thorapeatio hold on				
		rstanding that the therapeutic				
		ented was an approved NCI +				
	technique					
V 537	27E .0108 Client Ri	ights - Training in Sec Rest &	V 537			
	ITO	5				
	10A NCAC 27E .01					
		SICAL RESTRAINT AND				
	ISOLATION TIME-0	TUC				

Division of Health Service Regulation

STATE FORM 6899 F61011 If continuation sheet 9 of 17

Division of Health Service Regulation

	IT OF DEFICIENCIES		(VO) MULTIPL	E CONCERNICATION	(V2) DATE	CLIDVEV
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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		MHL066-024	B. WING		1	0/2024
NAME OF E	PROVIDER OR SUPPLIER	QTREET AD	DRESS CITY S	STATE, ZIP CODE		
IVAIVIL OF I	NOVIDEN ON SOLITEIEN			STATE, ZII GODE		
FAMILY A	ADVANTAGE LLC	3104 HWY		024		
			JRG, NC 27	831		T
(X4) ID		TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION SHOULD		(X5) COMPLETE
PRÉFIX TAG		SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI		DATE
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\/ 507	0 1		V/ 507			
V 537	Continued From pa	ge 9	V 537			
	(a) Seclusion, phys	sical restraint and isolation				
		nployed only by staff who have				
	been trained and ha					
	competence in the	proper use of and alternatives				
		s. Facilities shall ensure that				
		employ and terminate these				
		rained and have demonstrated				
	competence at leas					
	(b) Prior to providing direct care to people with					
		reatment/habilitation plan				
		interventions, staff including				
		employees, students or				
	volunteers shall cor	mplete training in the use of				
	seclusion, physical	restraint and isolation time-out				
	and shall not use th	nese interventions until the				
	training is complete	ed and competence is				
	demonstrated.					
	(c) A pre-requisite	for taking this training is				
	demonstrating com	petence by completion of				
		ng, reducing and eliminating				
	the need for restrict					
		all be competency-based,				
		e learning objectives,				
		(written and by observation of				
	,	objectives and measurable				
		ine passing or failing the				
		ovider periodically (minimum				
		raining that the camiles				
	` '					
	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					

Division of Health Service Regulation

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	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
EAMILY	ADVANTAGE LLC	3104 HW	′ 301 N			
FAMILY ADVANTAGE LLC GARYSB		JRG, NC 27	831			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON .	(X5)
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V 537	Continued From pa	ge 10	V 537			
	(understanding imminent danger to self and					
	others);	illent danger to sen and				
	,	on safety and respect for the				
		all persons involved (using				
		estrictive interventions and				
	incremental steps in					
		for the safe implementation				
	of restrictive interve					
	(5) the use of emergency safety					
	interventions which include continuous					
	assessment and monitoring of the physical and					
	psychological well-b	peing of the client and the safe				
	use of restraint thro	ughout the duration of the				
	restrictive interventi					
		procedures;				
		strategies, including their				
	importance and pur					
		ation methods/procedures.				
	(h) Service provide					
		itial and refresher training for				
	at least three years					
	` '	tation shall include:				
		ipated in the training and the				
	outcomes (pass/fail (B) when and); I where they attended; and				
	(C) when and (C)	•				
		ion of MH/DD/SAS may				
		documentation at any time.				
		ication and Training				
	Requirements:	loadon and Halling				
		shall demonstrate competence				
		testing in a training program				
		, reducing and eliminating the				
	need for restrictive					
		shall demonstrate competence				
		testing in a training program				
		seclusion, physical restraint				
	and isolation time-o					
		hall demonstrate competence				

Division	of Health Service Re	egulation	т			
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LEIED
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		MHL066-024	B. WING		09/30/2024	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS CITY S	STATE, ZIP CODE		
IVAIVIL OI I	NOVIDEN ON OUT LIEN	3104 HW		STATE, ZII OODE		
FAMILY A	ADVANTAGE LLC		JRG, NC 27	024		
	OUR MAA DV OTA				<u> </u>	
(X4) ID PREFIX		TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO		DATE
				DEFICIENCY)		
V 537	Continued From pa	ige 11	V 537			
	•					
	by scoring a passing grade on testing in an					
	instructor training p	ng shall be				
		, include measurable learning				
		able testing (written and by				
		avior) on those objectives and				
		ds to determine passing or				
	failing the course.	. 3				
	(5) The content of the instructor training the service provider plans to employ shall be					
		vision of MH/DD/SAS pursuant				
	to Subparagraph (j)					
		le instructor training programs				
		ot be limited to, presentation				
	of: (A) understan	iding the adult learner;				
		for teaching content of the				
	course;	for teaching content of the				
		n of trainee performance; and				
		tation procedures.				
		shall be retrained at least				
		nstrate competence in the use				
		cal restraint and isolation				
		ed in Paragraph (a) of this				
	Rule.					
	(8) Trainers s	shall be currently trained in				
		shall have coached experience				
		of restrictive interventions at				
		a positive review by the				
	coach.	,				
		shall teach a program on the				
	` ,	terventions at least once				
	annually.					
		shall complete a refresher				
		t least every two years.				
	(k) Service provide					
		nitial and refresher instructor				
	training for at least	three years.				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		MHL066-024	B. WING 09			R 9/ 30/2024	
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, ST	TATE, ZIP CODE			
FAMILY	ADVANTAGE LLC	3104 HW GARYSB	Y 301 N URG, NC 278:	31			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
V 537	(1) Documen (A) who partic outcome (pass/fail) (B) when and (C) instructor (2) The Divis review/request this (I) Qualifications of (1) Coaches requirements as a t (2) Coaches times, the course w (3) Coaches	tation shall include: sipated in the training and the ; d where they attended; and 's name. ion of MH/DD/SAS may documentation at any time. coaches: shall meet all preparation trainer. shall teach at least three which is being coached. shall demonstrate inpletion of coaching or truction. in shall be the same	V 537				
	failed to ensure 1 o demonstrated comprestrictive intervention. Review on 8/28/24 revealed: - Hired 1/30/23 - Title: Residention A Non-Crisis In Training certificate	view and interview, the facility f 3 audited staff (#3) petency in the proper use of ions. The findings are: of staff #3's personnel record al Counselor tervention Plus (NCI+) dated 2/1/24 of former client (FC) #5's					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
				R		
		MHL066-024	B. WING		09/3	0/2024
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
FAMILY	ADVANTAGE LLC	3104 HWY GARYSBI	/ 301 N JRG, NC 278	B31		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE
V 537	- Diagnoses of M Oppositional Defiar Attention-Deficit/Hy Review on 9/3/24 oreport dated 5/31/2- "Caller (FC #5) A male at the group the floor for no reasworks for the group - "Caller asked the caller wanted to go (advised) that the [st the subj face and to f*cking around with go outside to cool digrab water and the caller on the ground the building away from him aggressively challer threats and again dishouting obscenities violating staffs persidefensive block usi away from him" Interview on 8/29/24- FC #5 was disrifood and tearing up - He allowed FC calm himself down	lajor Depressive Disorder, it Disorder & peractivity Disorder f a 911 Communications 4 revealed: is a 13 YOM (year old male). home pushed the caller on on. Male is a [staff #3] and he home." ne [staff #3] for water and the outside and the caller advetaff #3] subj (subject) got into old him "Do you think I am you" and the caller wanted to own and turned back in to [staff #3] subj pushed the d and the caller walked out of om the subj" of the Incident Response m (IRIS) revealed: and defiant with no regards allclient then defiantly and need staff by shouting, making emanding snacks wile sed directly in staff's face; onal space; staff used a neg his hands in pushing client 4 staff #3 reported: upting the facility by stealing	V 537	BEITOLINO!)		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY				
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED			
					_			
		D WING		F				
		MHL066-024	B. WING		09/3	0/2024		
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS CITY S	STATE, ZIP CODE				
TW WILL OT	NOVIDEN ON OUT LIEN			717 (12, 211 OODE				
FAMILY	ADVANTAGE LLC	3104 HW						
		GARYSBI	JRG, NC 27	831				
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)		
PRÉFIX		MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL		COMPLETE		
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO DEFICIENCY)	PRIATE	DATE		
				BEI IOIEROT)				
V 537	Continued From pa	ae 14	V 537					
	-							
		'blur" and he could barely						
	remember what ha							
		g "fight or flight" and						
	implemented a "def	fensive shove"						
	- The "defensive	shove" was described as an						
	open hand shove to	FC #5's chest						
	- FC #5 fell onto	the couch						
	- FC #5 calmly q	ot up, grabbed the facility						
	phone and called the police							
	- The police investigated and concluded an "assault on a minor, but they (police) didn't press charges"							
	Attempted interviews on 8/28/24 & 8/29/24 with FC #5's guardian was unsuccessful because FC							
	#5's guardian didn't return any phone calls.							
	700 gaaralan alam	retain any phone dans.						
	Interview on 9/30/24 the NCI+ Chief Executive							
	Officer/Owner repo							
		block" described was not an						
	approved NCI + technique - If the situation escalated to aggression then							
	the staff should have moved himself out of the							
	way	t put hands on the client in that						
		t put hands on the client in that						
	manner							
	Attornated interview	10 on 9/29/24 9/20/24 9						
		vs on 8/28/24, 8/29/24 &						
		mpliance Officer/NCI+ sccessful because the						
		/NCI+ Instructor didn't return]		
	any phone calls prid	or to the exit of the survey.]		
	Internieur 0/0/04	the Ouglified Desferational						
		the Qualified Professional]		
	reported:]		
		ressive towards staff #3						
		"therapeutic move" on FC #5]		
		ic move" was described as two						
	opened hand shove							
- The "therapeutic move" was an approved NCI								

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL066-024			F 00/2	
					09/3	0/2024
NAME OF I	PROVIDER OR SUPPLIER	3104 HWY		STATE, ZIP CODE		
FAMILY A	ADVANTAGE LLC		JRG, NC 27	831		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
V 537	+ technique - FC #5 "just gradually pushed him out the waywasn't forceful and was just guidance to remove him out of his space" Interview on 9/30/24 the Licensee reported: - Staff #3 "implemented a therapeutic hold" on FC #5 - It was his understanding that the therapeutic hold FC #5 implemented was an approved NCI + technique - The Compliance Officer/NCI + Instructor told him the therapeutic hold FC #5 implemented was		V 537			
	an approved NCI +	technique				
V 736	27G .0303(c) Facili	ty and Grounds Maintenance	V 736			
	EXTERIOR REQUI (c) Each facility and maintained in a safe	03 LOCATION AND REMENTS I its grounds shall be e, clean, attractive and orderly e kept free from offensive				
		on and interview, the facility in a clean and attractive				
	 Marker and per bedroom walls Small hole in th client #2's bedroom Clients #3 & #4 	's bedroom had a medium nately 4 inches wide in the wall				
	Interview on 8/27/2	4 client #3 reported:				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
MHL066-024		B. WING		R 09/30/2024		
NAME OF P	ROVIDER OR SUPPLIER			STATE, ZIP CODE	1 03/3	0/2024
		3104 HWY		37.11.2, 2.11. 3332		
FAMILY A	DVANTAGE LLC	GARYSBL	JRG, NC 27	831		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE	D BE	(X5) COMPLETE DATE
	- Noticed the hole - The hole was a in - The facility "stir sewerevery once - "They (Manage pipes" Interview on 8/27/24 - Lived in the face - Didn't know wheeler was the seminary of the bathroom from someone usin the bathroom someone usin the bathroom someone usin the facility had the facility had the facility due to the seminary of the seminar	ility for a few weeks e in the wall in his bedroom lready there when he moved aks sometimes because of the and a while" ment) need to change the 4 client #4 reported: ility for a week at happened to the wall here when he was admitted stinks everyday and its not g the bathroom" smelled like sewer	V 736			

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