	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		BENTH IO/TION NOMBER.	A. BUILDING:			
		MHL0411156	B. WING			R <b>04/2024</b>
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
SEDRICI	('S PLACE		RELL DRIVE	2		
(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 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
V 000	INITIAL COMMENT	S	V 000			
	An annual and follo on 10/4/24. Deficie	w up survey was completed ncies were cited.				
	This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities.					
	The facility is licensed for 4 and has a current census of 2. The survey sample consisted of audits of 2 current clients.					
V 536	27E .0107 Client Ri Int.	ghts - Training on Alt to Rest.	V 536			
	practices that emph to restrictive interver (b) Prior to providir disabilities, staff inc employees, student demonstrate compe completing training other strategies for which the likelihood or injury to a persor property damage is (c) Provider agence based on state com compliance and der gathered. (d) The training sha include measurable measurable testing behavior) on those	D RESTRICTIVE mplement policies and nasize the use of alternatives intions. In g services to people with luding service providers, is or volunteers, shall etence by successfully in communication skills and creating an environment in of imminent danger of abuse in with disabilities or others or				

Division	of Health Service Re	egulation				
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		MHL0411156	B. WING			R 04/2024
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE		
SEDRIC	K'S PLACE		RRELL DRIVE	2		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C	ORRECTION	(X5)
PRÉFIX TAG		VMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	IE APPROPRIATE	COMPLETE DATE
V 536	Continued From pa	ge 1	V 536			
	by each service pro annually). (f) Content of the tr provider wishes to e the Division of MH/I Paragraph (g) of thi (g) Staff shall demo following core areas (1) knowledge people being served (2) recognizin behavior; (3) recognizin external stressors the disabilities; (4) strategies relationships with per (5) recognizin organizational factor disabilities; (6) recognizin assisting in the pers decisions about the (7) skills in as escalating behavior (8) communic and de-escalating per and (9) positive be means for people w activities which dire behaviors which are (h) Service provide documentation of in at least three years (1) Documen	onstrate competence in the s: e and understanding of the d; ng and interpreting human ng the effect of internal and hat may affect people with for building positive ersons with disabilities; ng cultural, environmental and ors that may affect people with ng the importance of and son's involvement in making ir life; ssessing individual risk for ; cation strategies for defusing potentially dangerous behavior; ehavioral supports (providing <i>v</i> ith disabilities to choose ctly oppose or replace e unsafe). ers shall maintain nitial and refresher training for				

Division	of Health Service Re	egulation			FURIN	APPROVED
STATEME	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		MHL0411156	B. WING			R 04/2024
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
		1210 TEF	RELL DRIVE			
SEDRIC	K'S PLACE	HIGH PO	INT, NC 2726	2		
(X4) ID	_	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORR		(X5)
PREFIX TAG		MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)		COMPLETE DATE
V 536	Continued From pa	ge 2	V 536			
	<ul> <li>(C) instructor</li> <li>(2) The Division review/request this</li> <li>(i) Instructor Qualific Requirements:</li> <li>(1) Trainers is by scoring 100% or a imed at preventing need for restrictive</li> <li>(2) Trainers is by scoring a passing instructor training performance; and</li> <li>(3) The training of the course.</li> <li>(4) The contest is substrated by the Division of behaviored by the Division of Subparagraph (i)</li> <li>(5) Acceptablic shall include but are (A) understand (B) methods for course;</li> <li>(C) methods performance; and</li> <li>(D) document (6) Trainers is teaching a training performance; and</li> <li>(7) Trainers is a imed at preventing and elimination of the course is a imed at preventing performance is a imed at preventing preventing performance is a perf</li></ul>	on of MH/DD/SAS may documentation at any time. ications and Training hall demonstrate competence testing in a training program reducing and eliminating the interventions. hall demonstrate competence g grade on testing in an rogram. ng shall be include measurable learning able testing (written and by vivor) on those objectives and ds to determine passing or ent of the instructor training the ns to employ shall be vision of MH/DD/SAS pursuant (5) of this Rule. e instructor training programs a not limited to presentation of: ding the adult learner; for teaching content of the for evaluating trainee ation procedures. hall have coached experience program aimed at preventing, ating the need for restrictive st one time, with positive				

STATEMEN	of Health Service Re IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED R	
		MHL0411156	B. WING			04/2024
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE		
SEDRICH	('S PLACE		RELL DRIVE NT, NC 2726	2		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	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) COMPLET DATE
V 536	instructor training a (j) Service provided documentation of ir training for at least (1) Docum (A) who partice outcomes (pass/fai (B) when and (C) instructor (2) The Divis request and review (k) Qualifications of (1) Coaches requirements as a to (2) Coaches the course which is (3) Coaches competence by cor train-the-trainer inst	shall complete a refresher t least every two years. rs shall maintain nitial and refresher instructor three years. mentation shall include: cipated in the training and the l); d where attended; and 's name. ion of MH/DD/SAS may this documentation any time. of Coaches: shall meet all preparation trainer. shall teach at least three times being coached. shall demonstrate npletion of coaching or	V 536			
	failed to ensure 1 o received annual tra	et as evidenced by: view and interview, the facility f 3 audited staff (staff #1) had ining on alternatives to ions. The findings are:				
	Review on 10/2/24 - A hire date of 5 ealth Service Regulation	of staff #1's record revealed: /2/18				

STATE FORM

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If continuation sheet 4 of 9

STATEME	of Health Service Re NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVE COMPLETED R 10/04/2024	
		MHL0411156	B. WING			
NAME OF	PROVIDER OR SUPPLIER			TATE, ZIP CODE		
SEDRIC	K'S PLACE		RELL DRIVE NT, NC 2726	2		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
V 536	<ul> <li>His training in a interventions expire</li> <li>No evidence of in alternatives to result in the interview on 10/2/24</li> <li>Administrative Assis</li> <li>Staff #1 had readin restrictive interve provided her with a training certificate</li> <li>She would attent training certificate p</li> <li>Prior to the close</li> </ul>	Iternatives to restrictive ad on 5/12/24 an updated training certificate strictive interventions 4 and on 10/4/24 with an stant revealed: ceived training in alternatives ntions; however, he had not copy of his most recent mpt to secure a copy of his rior to the close of the survey se of the survey on 10/4/24, eived a copy of an updated	V 536			
V 537	ITO 10A NCAC 27E .01 SECLUSION, PHYS ISOLATION TIME-0 (a) Seclusion, phys time-out may be en- been trained and ha competence in the to these procedures staff authorized to e procedures are retrr competence at lease (b) Prior to providin disabilities whose tri includes restrictive service providers, e volunteers shall cor seclusion, physical and shall not use th	SICAL RESTRAINT AND DUT sical restraint and isolation poloyed only by staff who have ave demonstrated proper use of and alternatives s. Facilities shall ensure that employ and terminate these ained and have demonstrated	V 537			

Division	of Health Service Re	equiation			FORM	APPROVED
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	СОМ	E SURVEY PLETED
		MHL0411156	B. WING			R 04/2024
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
SEDRIC	('S PLACE		RELL DRIVE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
V 537	Continued From pa demonstrated. (c) A pre-requisite t	ge 5 for taking this training is	V 537			
	demonstrating com training in preventin the need for restrict (d) The training sha include measurable	petence by completion of ig, reducing and eliminating ive interventions. Il be competency-based, e learning objectives,				
	<ul> <li>measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course.</li> <li>(e) Formal refresher training must be completed by each service provider periodically (minimum</li> </ul>					
	annually). (f) Content of the tr provider plans to er	raining that the service nploy must be approved by DD/SAS pursuant to				
	(g) Acceptable train but are not limited to	ning programs shall include, o, presentation of: information on alternatives to				
	(understanding imm others);	on when to intervene ninent danger to self and on safety and respect for the				
	rights and dignity of all persons involved (using concepts of least restrictive interventions and incremental steps in an intervention); (4) strategies for the safe implementation of restrictive interventions;					
	interventions which assessment and m psychological well-t use of restraint thro	onitoring of the physical and being of the client and the safe bughout the duration of the				
		on;   procedures;   strategies, including their				

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
						R
		MHL0411156	B. WING			04/2024
AME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE		
EDRIC	K'S PLACE		RELL DRIVE	2		
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	THE APPROPRIATE	COMPLET DATE
V 537	Continued From pa	ge 6	V 537			
	importance and pur					
		ation methods/procedures.				
	(h) Service provider					
	at least three years	itial and refresher training for				
		tation shall include:				
		ipated in the training and the				
	outcomes (pass/fail	);				
		where they attended; and				
	(C) instructor					
		on of MH/DD/SAS may				
	review/request this documentation at any time. (i) Instructor Qualification and Training					
	Requirements:					
	(1) Trainers 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-c					
		hall 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				
	failing the course.	measurable methods to determine passing or failing the course				
	(5) The content of the instructor training the					
	service provider plans to employ shall be					
		approved by the Division of MH/DD/SAS pursuant				
	to Subparagraph (j)					
		e instructor training programs				
	of:	ot be limited to, presentation				
		ding the adult learner;				
	1. 1 and oto tan					

C

Division	of Health Service Re	egulation			FORM	APPROVED
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		LETED
		MHL0411156	B. WING			२ <b>)4/2024</b>
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
SEDRICI	K'S PLACE		RELL DRIVE			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORREC	TION	(X5)
PREFIX TAG		YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)		COMPLETE DATE
V 537	Continued From pa	ge 7	V 537			
	course; (C) evaluation (D) document (7) Trainers s annually and demon of seclusion, physic time-out, as specific Rule. (8) Trainers s CPR. (9) Trainers s in teaching the use least two times with coach. (10) Trainers s use of restrictive int annually. (11) Trainers s instructor training at (k) Service provide documentation of in training for at least f (1) Documen (A) who partic outcome (pass/fail). (B) when and (C) instructor (2) The Divisi review/request this (I) Qualifications of (1) Coaches s times, the course w (3) Coaches s competence by con- train-the-trainer inst (m) Documentation	itial and refresher instructor three years. tation shall include: ipated in the training and the image: where they attended; and 's name. on of MH/DD/SAS may documentation at any time. Coaches: shall meet all preparation rainer. shall teach at least three hich is being coached. shall demonstrate npletion of coaching or truction.				
Division of H	ealth Service Regulation					

Division of Health Service Regulation STATE FORM

Division	of Health Service Re	egulation				
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY LETED
		MHL0411156	B. WING		F 10/0	२ <b>4/2024</b>
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
SEDDIC	K'S PLACE	1210 TER	RELL DRIVE			
SEDINIC		HIGH POI	NT, NC 2726	52		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	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 537	Continued From pa	ge 8	V 537			
	preparation as for t	rainers.				
Division of H	failed to ensure 1 o received annual tra restraint and isolati Review on 10/2/24 - A hire date of 5 - His training in s and isolation time-o - No evidence of in seclusion, physic time-out Interview on 10/2/2 Administrative Assi - Staff #1 had re- physical restraint and he had not provided recent training certifi- - She would atter training certificate p - Prior to the close	view and interview, the facility f 3 audited staff (staff #1) had ining on seclusion, physical on time-out. The findings are: of staff #1's record revealed: /2/18 seclusion, physical restraint out expired on 5/12/24 an updated training certificate cal restraint and isolation 4 and on 10/4/24 with an stant revealed: ceived training in seclusion, nd isolation time-out; however, d her with a copy of his most ficate mpt to secure a copy of his prior to the close of the survey se of the survey on 10/4/24, ceived a copy of an updated				