Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		A. BUILDING: _				
MHL059-101		B. WING		R-C 11/01/2024		
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	•	
6249 HARMONY GROVE ROAD						
BERKIBA	RANCH FARM FAMILY HO	NEBO, NC	28761			
(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 000	0 INITIAL COMMENTS		V 000			
	A complaint and follow up survey was completed on November 1, 2024. The complaint was unsubstantiated (NC#00222266). A deficiency was cited. This facility is licensed for the following service category: 10A NCAC 27G .5600F Supervised Living for Alternative Family Living. This facility is licensed for 3 and currently has a census of 3. The survey sample consisted of an audit of 1 current client.					
V 536	V 536 27E .0107 Client Rights - Training on Alt to Rest. Int. 10A NCAC 27E .0107 TRAINING ON ALTERNATIVES TO RESTRICTIVE INTERVENTIONS (a) Facilities shall implement policies and practices that emphasize the use of alternatives to restrictive interventions. (b) Prior to providing services to people with disabilities, staff including service providers, employees, students or volunteers, shall demonstrate competence by successfully completing training in communication skills and other strategies for creating an environment in which the likelihood of imminent danger of abuse or injury to a person with disabilities or others or property damage is prevented. (c) Provider agencies shall establish training based on state competencies, monitor for internal compliance and demonstrate they acted on data gathered. (d) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable		V 536			

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

(X6) DATE TITLE

Division of Health Service Regulation

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: R-C 11/01/202 NAME OF PROVIDER OR SUPPLIER BERRYBRANCH FARM FAMILY HOME STREET ADDRESS, CITY, STATE, ZIP CODE 6249 HARMONY GROVE ROAD NEBO, NC 28761	
NAME OF PROVIDER OR SUPPLIER BERRYBRANCH FARM FAMILY HOME STREET ADDRESS, CITY, STATE, ZIP CODE 6249 HARMONY GROVE ROAD NEBO, NC 28761	004
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NEBO, NC 28761	
OUR DESCRIPTION OF DEPOSIT	
PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CONTROL OF THE PREFIX (EACH CORRECTIVE ACTION SHOULD	(X5) COMPLETE DATE
V 536 Continued From page 1 V 536	
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 wishes to employ must be approved by the Division of MH/DD/SAS pursuant to Paragraph (g) of this Rule. (g) Staff shall demonstrate competence in the following core areas: (1) knowledge and understanding of the people being served; (2) recognizing and interpreting human behavior; (3) recognizing the effect of internal and external stressors that may affect people with disabilities; (4) strategies for building positive relationships with persons with disabilities; (5) recognizing cultural, environmental and organizational factors that may affect people with disabilities; (6) recognizing the importance of and assisting in the person's involvement in making decisions about their life; (7) skills in assessing individual risk for escalating behavior; (8) communication strategies for defusing and de-escalating potentially dangerous behavior; and (9) positive behavioral supports (providing means for people with disabilities to choose activities which directly oppose or replace behaviors which are unsafe). (h) Service providers shall maintain documentation of initial and refresher training for at least three years.	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED				
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BERRYBR	BERRYBRANCH FARM FAMILY HOME 6249 HARMONY GROVE ROAD							
		NEBO, N	IC 28761					
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V 536	Continued From page	2	V 536					
	Continued From page	5.2						
	(A) who particip	pated in the training and the						
	outcomes (pass/fail);							
	**	where they attended; and						
	(C) instructor's							
	• •	n of MH/DD/SAS may						
	` '	ocumentation at any time.						
	(i) Instructor Qualification	•						
	* *	ations and Training						
	Requirements:	all demonstrate competence						
	• ,	all demonstrate competence						
	-	esting in a training program						
	aimed at preventing, reducing and eliminating the							
	need for restrictive interventions.							
	(2) Trainers shall demonstrate competence							
	by scoring a passing grade on testing in an instructor training program.							
	(3) The training	g shall be						
	competency-based, in	nclude measurable learning						
		ole testing (written and by						
	-	ior) on those objectives and						
		to determine passing or						
	failing the course.	to dotermine passing of						
	(4) 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 (i)(5) of this Rule.							
	(5) Acceptable instructor training programs							
	shall include but are not limited to presentation of:							
		ng the adult learner;						
	(B) methods fo	r teaching content of the						
	course;							
	(C) methods fo	r evaluating trainee						
	performance; and							
	(D) documentat	tion procedures.						
		all have coached experience						
		ogram aimed at preventing,						
	reducing and eliminating the need for restrictive interventions at least one time, with positive							
		one une, with positive						
	review by the coach.	all tagah a training a super						
	(7) Trainers shall teach a training program							

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED				
		A. BUILDING: _						
MHL059-101		B. WING		R-C 11/01/2024				
NAME OF P	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
BERRYBR	RANCH FARM FAMILY H	OME 6249 HAR NEBO, NO	MONY GROVE 28761	ROAD				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIV (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE		
V 536	need for restrictive in annually. (8) Trainers shi instructor training at III (j) Service providers documentation of inititraining for at least th (1) Docume (A) who particip outcomes (pass/fail); (B) when and v (C) instructor's (2) The Division request and review th (k) Qualifications of 0 (1) Coaches shi requirements as a train (2) Coaches shi the course which is b (3) Coaches shi competence by competrain-the-trainer instructions.	reducing and eliminating the terventions at least once all complete a refresher east every two years. shall maintain ial and refresher instructor ree years. entation shall include: ented in the training and the where attended; and name. In of MH/DD/SAS may his documentation any time. Coaches: hall meet all preparation liner. In all teach at least three times eing coached. In all demonstrate oletion of coaching or	V 536					
	This Rule is not met as evidenced by: Based on record review and interview, 1 of 1 paraprofessional (AFL provider) failed to demonstrate competency in the use of alternative to restrictive intervention techniques. The findings are:							

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED			
		A. DOILDING.		D.C.			
MHL059-101			B. WING		R-C 11/01/2024		
NAME OF PI	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE						
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<u> </u>	NEBO, NC 28761						
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V 536	36 Continued From page 4		V 536				
	revealed: -Date of Hire: 9/1/21Job Title: Long Term (LTCS)/Paraprofessiot-Alternatives in Restrict dated 8/14/24. Review on 9/24/24 arrecord revealed: -Date of Admission: 1-Diagnoses: Mild Inter Disability; Bipolar Dis Personality D/O, Post Attention Deficit Hyper Palsy; and Hypothyrous Review on 11/1/24 of 9/11/24 revealed: -"[Client #1] came how angry with PSR staff. redirect [Client #1]I (she) continued to yesumbegan hitting [AFL] her infant grandchild.	ictive Intervention Training and 10/31/24 of Client #1's 2/1/23. Illectual Developmental order (D/O); Borderline traumatic Stress Disorder, eractivity D/O; Cerebral idism. facility incident report dated me from PSR (day program) [AFL provider] attempted to out was unsuccessful					
	Interview on 9/24/24 with Client#1 revealed: -admitted to trying to hit the AFL Provider when she came home that day "I was trying to aim for her (AFL provider) not						
	the babyshe slapped me in the face." - "I was upsetwanted her to feel how I feltshe could have put the baby down." - " tried to get me to sit down to calm downI pinched her to get her off meI didn't want to hear itpushed me off the chair" -AFL provider was yelling at her.						

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
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(V4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	COMPLETE DATE
V 536	Continued From page	e 5	V 536			
	-day program staff haduring facility drop of her (day program staff haduring facility drop of her (day program staff haduring facility. - Client #1 became up facility. - "heard yellingnar" from both sides (AFI-saw Client #1 hit the AFL provider was he happened. -AFL provider slappe thought it was "self-copart). Interview on 9/24/24 revealed: -Client #1 was upset the day program. -Client #1 threw her before coming inside told Client #1 to sit communication "usually that works." -when Client #1 came threw her baby doll a bookbag around." -Client #1 continued threw her baby doll a bookbag around." -Client #1 continued threw her baby doll a bookbag around." -Client #1 continued threw her baby doll a bookbag around." -Client #1 continued threw her baby doll a bookbag around." -Client #1 continued threw her baby doll a bookbag around." -Client #1 continued threw her baby doll a bookbag around." -Client #1 continued threw her baby doll a bookbag around." -Client #1 continued threw her baby doll a bookbag around." -Client #1 continued threw her baby doll a bookbag around." -Client #1 continued threw her baby doll a bookbag around." -Client #1 continued threw her baby doll a bookbag around."	pset and she went inside the me calling, and cursing from, and Client #1)." AFL provider in the arm. olding the baby when it defense" (on AFL provider's with the AFL Provider when she came home from the lalloween bucket outside fown and to calm down, the inside the facility, she and was "slinging her to escalate. The my right arm was covering the stomach. I turned and my thit her arm/hand clipped her client #1 in the process, an now"				

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-AFL provider contacted him after the incident

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X A. BUILDING:			X3) DATE SURVEY COMPLETED		
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NAME OF P	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE						
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V 536	Continued From page		V 536				
V 536	with Client #1Client #1 had becom AFL provider and had -had a team meeting	e aggressive towards the	V 536				

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