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	MHL026-857	A. BUILDING: _____ B. WING _____	R 10/16/2024

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V 000	INITIAL COMMENTS An annual, complaint and follow up survey was completed on October 16, 2024. The complaint was substantiated (Intake #NC00222740). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600A Supervised Living for Adults with Mental Illness. This facility is licensed for 6 and currently has a census of 6. The survey sample	V 000	All staff will receive refresher training on first aid, CPR, Heimlich maneuver, and infectious diseases. Training received will be updated to ensure compliance.	
V 108	consisted of audits of 4 current clients. 27G .0202 (F-I) Personnel Requirements 10A NCAC 27G .0202 PERSONNEL REQUIREMENTS (f) Continuing education shall be documented. (g) Employee training programs shall be provided and, at a minimum, shall consist of the following: (1) general organizational orientation; (2) training on client rights and confidentiality as delineated in 10A NCAC 27C, 27D, 27E, 27F and 10A NCAC 26B; (3) training to meet the mh/dd/sa needs of the client as specified in the treatment/habilitation plan; and (4) training in infectious diseases and bloodborne pathogens. (h) Except as permitted under 10a NCAC 27G .5602(b) of this Subchapter, at least one staff member shall be available in the facility at all times when a client is present. That staff member shall be trained in basic first aid including seizure management, currently	V 108	V108:Deficiency 1:Missing First Aid/CPR Documentation Immediate Action: The house Manager will contact the trainer to obtain a duplicate certificate verifying first aid/CPR training. For Staff #2 and Staff #3, are no longer employed by the company.. Responsible Staff: Human Resources Manager Policy Update: Revise the onboarding process to require immediate submission of first aid/CPR certificates for newly hired staff. Include a checklist in the personnel file to ensure all required documentation is completed before staff are allowed to work independently. Responsible Staff: Compliance Officer Completion Date: Staff Training: Train Human Resources Staff on the updated documentation requirements and ensure all personnel files are reviewed quarterly for compliance.	

	trained to provide cardiopulmonary resuscitation and trained in the Heimlich maneuver or other first aid techniques such as those provided by Red Cross,			

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V 108	Continued From page 1 the American Heart Association or their equivalence for relieving airway obstruction. (i) The governing body shall develop and implement policies and procedures for identifying, reporting, investigating and controlling infectious and communicable diseases of personnel and clients. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 3 of 4 audited (House Manager, #2 and #3) had current first aid/cardiopulmonary resuscitation (CPR) training. The findings are: Review on 10/16/24 of the House Manager's personnel record revealed: - Hire date 12/11/23. - No documentation of current first aid/CPR training. Review on 10/16/24 of staff #2's record revealed: -Hire date 06/01/24. -Habilitation Technician. -No documentation of current first aid/CPR training. Review on 10/146/24 of staff #3's record revealed: -Hire date not in the record. -No documentation of current first aid/CPR training. During interview on 10/16/24 the House Manager revealed:	V 108	Responsible Staff: Training Coordinator Deficiency 2: Ongoing Compliance with First Aid/CPR Requirements Training Plan: Schedule ongoing first aid/CPR training for all staff to maintain certifications. Ensure all staff complete training before certification expiration. Responsible Staff: Human Resources Manager Completion Date: Ongoing. Monitoring System: Implement a tracking system to monitor the expiration dates of first aid/CPR certifications and notify staff 60 days before expiration. Responsible Staff: Administrative Assistant Long-Term Monitoring Quarterly Audits: Conduct quarterly audits of personnel Records to verify compliance with first aid/CPR training requirements. Responsible Staff: Quality Assurance Team Completion Date: Ongoing Documentation protocols: Require that all training certificates are submitted and filed electronically in a centralized personnel database upon completion. Responsible Staff: Human Resources Staff Completion Date All corrective actions will be completed by 11/30/2024 We are committed to ensuring that all personnel meet the required training standards to provide safe and effective care to clients.	

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V 108	Continued From page 2 -Staff #1 was her husband and she took first aid/CPR the same date as her husband. -She did not know why the office did not have her certificate. -She would contact the trainer to get another copy of her training. Attempted interview on 10/16/24 by phone with staff #2 and #3 was unsuccessful and no return call was made by the exit date. During interview on 10/16/24 the Human Resource staff revealed: -Staff #2 had not worked with the agency long and her record was not complete. -She was unable to locate the certificates for the other staff.	V 108		
V 112	27G .0205 (C-D) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (c) The plan shall be developed based on the assessment, and in partnership with the client or legally responsible person or both, within 30 days of admission for clients who are expected to receive services beyond 30 days. (d) The plan shall include: (1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement; (2) strategies; (3) staff responsible; (4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both; (5) basis for evaluation or assessment of	V 112	v112: Deficiency 1 : Missing Written Consent or Explanation: Immediate Action: Contact the guardian to obtain written consent or agreement for the PCP or document why consent cannot be obtained. Responsible Staff: Case Manager/House Manager Policy Update: Revise the facility's policy to ensure that guardians,legally responsible persons,or clients sign all treatment plans or provide a documented explanation if signatures cannot be obtained. Responsible Staff: Compliance Officer Staff Training: Train Staff on the importance of obtaining written consent and documenting all efforts to secure it. Responsible Staff: Training Coordinator Deficiency 2: Missing Goals and Strategies for Unsupervised Time Immediate Action: Revise client #1's Person-Centered Plan to include: Specific goals for managing unsupervised time in the community.	

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V 112	Continued From page 3 outcome achievement; and (6) written consent or agreement by the client or responsible party, or a written statement by the provider stating why such consent could not be obtained. This Rule is not met as evidenced by: Based on observation, record reviews and interviews, the facility failed to have a Person-Centered Plan with written consent or agreement by the client or responsible party or a written statement by the provider stating why such consent could not be obtained and failed to develop and implement goals and strategies in the treatment/habilitation plan to address the client's unsupervised time in the community affecting 1 of 4 audited clients (#1). The findings are: Review on 10/10/16/24/24 of client #1's record revealed: - Admission date 04/13/22. - Diagnosis of Cannabis Use Disorder, Cocaine Use Disorder, Schizoaffective Disorder and Anxiety Disorder. -Person-Centered Plan dated 05/01/24 was not signed by the guardian. -The Person-Centered Plan did not have goals or strategies for unsupervised time in the community.	V 112	Detailed strategies for ensuring safety and addressing risks. Staff responsibilities and timelines for reviewing progress. Responsible Staff: Clinical Team Client/Guardian involvement: Schedule a meeting with client #1 and their guardian to discuss the revised goals and strategies, ensuring input and agreement. Responsible Staff: Case Manager Plan Implementation: Implement and monitor the strategies for addressing unsupervised time. Document progress and challenges in client #1's record during weekly reviews. Responsible Staff: Direct Care Staff and Clinical Team Completion Date: Ongoing Long-Term Monitoring Quality Assurance Audits: Conduct monthly audits of all Person- Centered Plans to ensure compliance with regulatory requirements, including signed consents and appropriate goals and strategies. Responsible Staff: Case Manager Plan Implementation: Implement and monitor the strategies for addressing unsupervised time. Document progress and challenges in client #1's record during weekly reviews. Responsible Staff: Direct Care Staff and Clinical Team Completion Date: Ongoing Long-Term Monitoring Quality Assurance Audits: Conduct monthly audits of all Person-Centered Plans to ensure compliance with regulatory requirements, including signed consents and appropriate goals and strategies.	

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V 112	Continued From page 4 Observation on 10/15/24 at approximately 10:00am and 10/16/24 at approximately 11:00am client #1 was picked up from the facility by his employer. During interview on 10/16/24 client #1 revealed: -He was unsure how long he had lived at the facility. -He went to work Monday-Friday. -He did landscaping work. -He would get back to the facility at either 6:00pm or 6:30pm. -Staff was not with him when he went to work. During interview on 10/15/24 the House Manager revealed: -Client #1 went to work every day. -He was picked up at the facility in the morning and he would return in the evening. During interview on 10/16/24 the Qualified Professional revealed: -He was not aware client #1 going to work needed to be included in his Person-Centered Plan. -He would add the unsupervised time to the Person-Centered Plan.	V 112	Responsible Staff: Quality Assurance Team Completion Date: Ongoing Team Team Meetings: Discuss clients goals,strategies, and progress during weekly staff meetings to ensure ongoing focus on individualized treatment plans. Responsible Staff: House Manager and Clinical Team Guardian Engagement: Create a spreadsheet system for obtaining and following up on guardian consents. Responsible Staff: Administrative Staff Completion Date All corrective actions will be completed by We are committed to ensuring the development and implementation of comprehensive, individualized treatment plans and compliance with all regulatory requirements.	
V 114	27G .0207 Emergency Plans and Supplies 10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES (a) Each facility shall develop a written fire plan and a disaster plan and shall make a copy of these plans available to the county emergency services agencies upon request. The plans shall include evacuation procedures and routes. (b) The plans shall be made available to all staff	V 114	v114:Deficiency:Failure to conduct and Disaster Drills Immediate Action: Corrective Action: Conduct disaster drill immediately for all shifts to ensure comp quarterly requirements responsible Staf Manager and Shift Supervisors Corrective Action: Updated the emerger preparedness policy to clearly outline: Quarterly disaster drill requirements . Drill frequency and shift- specific require Proper documentation protocols for drills Responsible Staff: Compliance Officer	

			Staff Training: Corrective action: Train all staff, including shift supervisors,on: Disaster drill requirements. Documentation procedures. Simulating real emergency responses. Responsible Staff: Training Coordinator or Qualified Emergency Preparedness Trainer Posting Procedures: Corrective Action:Post evacuation procedures and routes prominently in all common areas and staff offices.	

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V 114	Continued From page 5 and evacuation procedures and routes shall be posted in the facility. (c) Fire and disaster drills in a 24-hour facility shall be held at least quarterly and shall be repeated for each shift. Drills shall be conducted under conditions that simulate the facility's response to fire emergencies. (d) Each facility shall have a first aid kit accessible for use. This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to ensure disaster drills were held at least quarterly and repeated on each shift. The findings are: Review on 10/15/24 of the facility's record for fire and disaster drills revealed: -No documentation of disaster drills from September 2023 to September 2024. During interview on 10/14/24 the House Manager revealed: -She starting working at the facility in December 2023. -She made sure the fire drills were completed every month. -She was not aware disaster drills had to be done. -She would ensure they were completed. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 114	Responsible Staff: House Manager Audit and Monitoring: Corrective Action: Conduct monthly reviews of drill documentation to ensure compliance. Implement a drill tracking system to alert staff when drills are due for each shift. Responsible Staff: Quality Assurance Team Completion Date: Ongoing Compliance Verification Evidence of Correction: Ensuring all shifts complete the disaster drill logs for all shifts. Updated policies and staff Acknowledgment forms for training sessions Photos of posted evacuation routes. Long-Term Monitoring: Monthly review of emergency drill compliance by the Quality Assurance Team. Quarterly reports to the facility administrator confirming compliance with drill requirements.	

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V 131	G.S. 131E-256 (D2) HCPR - Prior Employment Verification G.S. §131E-256 HEALTH CARE PERSONNEL REGISTRY (d2) Before hiring health care personnel into a health care facility or service, every employer at a health care facility shall access the Health Care Personnel Registry and shall note each incident of access in the appropriate business files. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure the Health Care Personnel Registry (HCPR) was accessed prior to employment for 4 of 4 audited staff (House Manager, #1, #2 and the Lead House Manager). The findings are: Review on 10/16/24 of the House Manager's personnel record revealed: - Hire date 12/11/23. - No documentation of HCPR was accessed prior to hire. Review on 10/16/24 of staff #1's personnel record revealed: -Hire date 06/26/23. -The HCPR was assessed on 02/09/24. Review on 10/16/24 of staff #2's personnel record revealed: -Hire date 06/01/24. -No documentation of HCPR was accessed prior	V 131	V131: Deficiency: Failure to Access HCPR Prior to Employment Policy Update: Corrective Action: Revise the hiring policy to include a mandatory pre-employment checklist to verify: HCPR is accessed and documented prior to offering employment. The access date is noted in the personnel file. Responsible Staff: Compliance Officer Staff Training: Corrective Action: Train Human Resources staff on the requirement to access and document HCPR verification before employment. Include guidance on: Using the HCPR system. Recording access dates in personnel files. Responsible Staff: Compliance Officer or Qualified Trainer Audit and Monitoring: Corrective Action: Will implement a bi-weekly audit of all new hire personnel files to ensure compliance with HCPR verification requirements. Responsible Staff: Quality Assurance Team Completion Date: Ongoing Compliance Verification Evidence of Correction: showing HCPR was l current staff. policy that outlines HCPR ords and signed nts from HR training itoring: l reviews by the Human ctor. iance reviews by the icer to ensure adherence ements. Documentation accessed for a Updated hiring requirements. Attendance rec acknowledgme sessions. Long-Term Mor Monthly interna Resources Dire Quarterly comp Compliance Off to HCPR requir	

PRINTED: 11/05/2024
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V 131	Continued From page 7 to hire. Review on 10/16/24 of staff #3's personnel record revealed: -Hire date April 2024. -No documentation of HCPR was accessed prior to hire. During the exit interview the Human Resource gave no response to the HCPR not being completed prior to hire.	V 131		
V 133	G.S. 122C-80 Criminal History Record Check G.S. §122C-80 CRIMINAL HISTORY RECORD CHECK REQUIRED FOR CERTAIN APPLICANTS FOR EMPLOYMENT. (a) Definition. - As used in this section, the term "provider" applies to an area authority/county program and any provider of mental health, developmental disability, and substance abuse services that is licensable under Article 2 of this Chapter. (b) Requirement. - An offer of employment by a provider licensed under this Chapter to an applicant to fill a position that does not require the applicant to have an occupational license is conditioned on consent to a State and national criminal history record check of the applicant. If the applicant has been a resident of this State for less than five years, then the offer of employment is conditioned on consent to a State and national criminal history record check of the applicant. The national criminal history record check shall include a check of the applicant's fingerprints. If the applicant has been a resident of this State for five years or more, then the offer is conditioned on consent to a State criminal history record check of the applicant. A provider shall not	V 133	v133: Deficiency: Failure to Conduct Timely Criminal History Checks Immediate Action: Corrective Action: Initiate and complete criminal history record checks for the House Manager and Staff #2 immediately. Responsible Staff: Human Resources Director Policy Update: Corrective Action: Revise the hiring policy to include a mandatory checklist ensuring: All conditional offers of employment are documented with dates. Criminal history record check requests are submitted within five business days of the offer. Verification of completed criminal history checks before new hires begin employment. Responsible Staff: Compliance Officer Staff Training: Corrective Action: Train Human Resources staff on the legal requirements for criminal history record checks, focusing on: Submission deadlines (within five business days). Documentation protocols to track Compliance. Maintaining confidentiality of criminal history records. Responsible Staff: Compliance Officer or Qualified Trainer Criminal records will be submitted within before hiring. Audit and Monitoring: Corrective Action: Implement a monthly audit of personnel files to ensure: Criminal history checks are conducted and documented for all new hires. Timely submission of required records.	

			Responsible Staff: Quality Assurance Team Completion Date: Ongoing Compliance Verification Evidence of Correction: Documentation of completed criminal history record checks for the House Manager and Staff #2. The hose manger had previous criminal record before hiring. Updated hiring policy outlining criminal history record check requirements. Attendance records and signed acknowledgments from HR staff training sessions. Long-Term Monitoring: Quarterly compliance reviews by the Human Resources Director. Spot-checks by the Compliance Officer to verify adherence to criminal history check timelines.	

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V 133	Continued From page 8 employ an applicant who refuses to consent to a criminal history record check required by this section. Except as otherwise provided in this subsection, within five business days of making the conditional offer of employment, a provider shall submit a request to the Department of Justice under G.S. 114-19.10 to conduct a criminal history record check required by this section or shall submit a request to a private entity to conduct a State criminal history record check required by this section. Notwithstanding G.S. 114-19.10, the Department of Justice shall return the results of national criminal history record checks for employment positions not covered by Public Law 105-277 to the Department of Health and Human Services, Criminal Records Check Unit. Within five business days of receipt of the national criminal history of the person, the Department of Health and Human Services, Criminal Records Check Unit, shall notify the provider as to whether the information received may affect the employability of the applicant. In no case shall the results of the national criminal history record check be shared with the provider. Providers shall make available upon request verification that a criminal history check has been completed on any staff covered by this section. A county that has adopted an appropriate local ordinance and has access to the Division of Criminal Information data bank may conduct on behalf of a provider a State criminal history record check required by this section without the provider having to submit a request to the Department of Justice. In such a case, the county shall commence with the State criminal history record check required by this section within five business days of the conditional offer of employment by the provider. All criminal history information received by the	V 133		

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V 133	Continued From page 9 provider is confidential and may not be disclosed, except to the applicant as provided in subsection (c) of this section. For purposes of this subsection, the term "private entity" means a business regularly engaged in conducting criminal history record checks utilizing public records obtained from a State agency. (c) Action. - If an applicant's criminal history record check reveals one or more convictions of a relevant offense, the provider shall consider all of the following factors in determining whether to hire the applicant: (1) The level and seriousness of the crime. (2) The date of the crime. (3) The age of the person at the time of the conviction. (4) The circumstances surrounding the commission of the crime, if known. (5) The nexus between the criminal conduct of the person and the job duties of the position to be filled. (6) The prison, jail, probation, parole, rehabilitation, and employment records of the person since the date the crime was committed. (7) The subsequent commission by the person of a relevant offense. The fact of conviction of a relevant offense alone shall not be a bar to employment; however, the listed factors shall be considered by the provider. If the provider disqualifies an applicant after consideration of the relevant factors, then the provider may disclose information contained in the criminal history record check that is relevant to the disqualification, but may not provide a copy of the criminal history record check to the applicant. (d) Limited Immunity. - A provider and an officer or employee of a provider that, in good faith, complies with this section shall be immune from	V 133		

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V 133	Continued From page 10 civil liability for: (1) The failure of the provider to employ an individual on the basis of information provided in the criminal history record check of the individual. (2) Failure to check an employee's history of criminal offenses if the employee's criminal history record check is requested and received in compliance with this section. (e) Relevant Offense. - As used in this section, "relevant offense" means a county, state, or federal criminal history of conviction or pending indictment of a crime, whether a misdemeanor or felony, that bears upon an individual's fitness to have responsibility for the safety and well-being of persons needing mental health, developmental disabilities, or substance abuse services. These crimes include the criminal offenses set forth in any of the following Articles of Chapter 14 of the General Statutes: Article 5, Counterfeiting and Issuing Monetary Substitutes; Article 5A, Endangering Executive and Legislative Officers; Article 6, Homicide; Article 7A, Rape and Other Sex Offenses; Article 8, Assaults; Article 10, Kidnapping and Abduction; Article 13, Malicious Injury or Damage by Use of Explosive or Incendiary Device or Material; Article 14, Burglary and Other Housebreakings; Article 15, Arson and Other Burnings; Article 16, Larceny; Article 17, Robbery; Article 18, Embezzlement; Article 19, False Pretenses and Cheats; Article 19A, Obtaining Property or Services by False or Fraudulent Use of Credit Device or Other Means; Article 19B, Financial Transaction Card Crime Act; Article 20, Frauds; Article 21, Forgery; Article 26, Offenses Against Public Morality and Decency; Article 26A, Adult Establishments; Article 27, Prostitution; Article 28, Perjury; Article 29, Bribery; Article 31, Misconduct in Public Office; Article 35, Offenses Against the	V 133		

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	MHL026-857	A. BUILDING: _____ B. WING _____	R 10/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELITE CARE SERVICES AT MIDDLE RD	711 MIDDLE ROAD FAYETTEVILLE, NC 28302

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V 133	Continued From page 11 Peace; Article 36A, Riots and Civil Disorders; Article 39, Protection of Minors; Article 40, Protection of the Family; Article 59, Public Intoxication; and Article 60, Computer-Related Crime. These crimes also include possession or sale of drugs in violation of the North Carolina Controlled Substances Act, Article 5 of Chapter 90 of the General Statutes, and alcohol-related offenses such as sale to underage persons in violation of G.S. 18B-302 or driving while impaired in violation of G.S. 20-138.1 through G.S. 20-138.5. (f) Penalty for Furnishing False Information. - Any applicant for employment who willfully furnishes, supplies, or otherwise gives false information on an employment application that is the basis for a criminal history record check under this section shall be guilty of a Class A1 misdemeanor. (g) Conditional Employment. - A provider may employ an applicant conditionally prior to obtaining the results of a criminal history record check regarding the applicant if both of the following requirements are met: (1) The provider shall not employ an applicant prior to obtaining the applicant's consent for criminal history record check as required in subsection (b) of this section or the completed fingerprint cards as required in G.S. 114-19.10. (2) The provider shall submit the request for a criminal history record check not later than five business days after the individual begins conditional employment. (2000-154, s. 4; 2001-155, s. 1; 2004-124, ss. 10.19D(c), (h); 2005-4, ss. 1, 2, 3, 4, 5(a); 2007-444, s. 3.)	V 133		

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V 133	Continued From page 12 This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure the criminal history record check was requested within five business days of making the conditional offer of employment affecting two of four audited staff (House Manager and #2). The findings are: Finding #1: Review on 10/16/24 of the House Manager's personnel record revealed: - Hire date 12/11/23. - No documentation of a criminal history check completed. Review on 10/16/24 of staff #2's personnel record revealed: -Hire date 06/01/24. - No documentation of a criminal history check completed. During the exit interview the Human Resource gave no response to the criminal history record check not being completed.	V 133		
V 367	27G .0604 Incident Reporting Requirements 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall report all level II incidents, except deaths, that occur during the provision of billable services or while the consumer is on the providers premises or level III incidents and level II deaths involving the clients to whom the provider rendered any service within 90 days prior to the incident to the LME responsible for the catchment area where	V 367	v 367 : Deficiency: Failure to Submit Corrective Action: Submit all missing incident reports for the above incidents in IRIS within 48 hours. Responsible Staff: Facility Licensee or Designated Incident Manager Policy Update: Corrective Action: Revise the facility's Incident Reporting Policy to include: A mandatory internal reporting timeline (e.g., within 24 hours of the incident). Clear staff responsibilities for entering incidents into IRIS within 72 hours. Responsible Staff: Compliance Officer Staff Training: Corrective Action: Conduct mandatory staff training on incident reporting requirements, focusing on: The distinction between Level I, II, and III incidents. Proper use of IRIS and documentation protocols. Timelines for reporting and consequences of non-compliance. Responsible Staff: Compliance Officer or Qualified Trainer Audit and Monitoring: Corrective Action: Implement a monthly audit process to ensure:	

			All reportable incidents are entered into IRIS within the required timeframe. Incident reports are complete and accurate. Responsible Staff: Quality Assurance Team Completion Date: Ongoing Compliance Verification Evidence of Correction: Training attendance records and signed acknowledgments from staff. Updated Incident Reporting Policy. Long-Term Monitoring: Quarterly reviews of incident reporting compliance by the Program Director. Feedback from LME/MCO on the timeliness and quality of submitted reports. All corrective actions will be completed by 11/30/2024. We are committed to ensuring timely and accurate incident reporting and maintaining compliance with all regulatory requirements.	

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V 367	Continued From page 13 services are provided within 72 hours of becoming aware of the incident. The report shall be submitted on a form provided by the Secretary. The report may be submitted via mail, in person, facsimile or encrypted electronic means. The report shall include the following information: (1) reporting provider contact and identification information; (2) client identification information; (3) type of incident; (4) description of incident; (5) status of the effort to determine the cause of the incident; and (6) other individuals or authorities notified or responding. (b) Category A and B providers shall explain any missing or incomplete information. The provider shall submit an updated report to all required report recipients by the end of the next business day whenever: (1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or (2) the provider obtains information required on the incident form that was previously unavailable. (c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including: (1) hospital records including confidential information; (2) reports by other authorities; and (3) the provider's response to the incident. (d) Category A and B providers shall send a copy of all level III incident reports to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of becoming aware of the incident. Category A	V 367	All reportable incidents are entered into IRIS within the required timeframe. Incident reports are complete and accurate. Responsible Staff: Quality Assurance Team Completion Date: Ongoing Compliance Verification Evidence of Correction: Training attendance records and signed acknowledgments from staff. Updated Incident Reporting Policy. Long-Term Monitoring: Quarterly reviews of incident reporting compliance by the Program Director. Feedback from LME/MCO on the timeliness and quality of submitted reports. All corrective actions will be completed by 11/30/2024. We are committed to ensuring timely and accurate incident reporting and maintaining compliance with all regulatory requirements.	

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V 367	Continued From page 14 providers shall send a copy of all level III incidents involving a client death to the Division of Health Service Regulation within 72 hours of becoming aware of the incident. In cases of client death within seven days of use of seclusion or restraint, the provider shall report the death immediately, as required by 10A NCAC 26C .0300 and 10A NCAC 27E .0104(e)(18). (e) Category A and B providers shall send a report quarterly to the LME responsible for the catchment area where services are provided. The report shall be submitted on a form provided by the Secretary via electronic means and shall include summary information as follows: (1) medication errors that do not meet the definition of a level II or level III incident; (2) restrictive interventions that do not meet the definition of a level II or level III incident; (3) searches of a client or his living area; (4) seizures of client property or property in the possession of a client; (5) the total number of level II and level III incidents that occurred; and (6) a statement indicating that there have been no reportable incidents whenever no incidents have occurred during the quarter that meet any of the criteria as set forth in Paragraphs (a) and (d) of this Rule and Subparagraphs (1) through (4) of this Paragraph. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure an incident report was	V 367		

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V 367	Continued From page 15 submitted to the Local Management Entity (LME)/Managed Care Organization (MCO) within 72 hours as required. The findings are: Review on 10/16/24 of the North Carolina Incident Response Improvement System (IRIS) revealed: - No documentation a level II IRIS report had been completed regarding client #2 and client #4 police assistance due to behaviors. Review on 10/16/24 of the facility's level 1 incident report revealed: -"07/03/24-[Client #2] walked off from the group home because him and [Client #4] had a disagreement the time was at 10:30am. I called 911. The police came out to the group home and talked to me about what's going on. Then they said they will go look for him." -"10/6/24- To whom it may concern. [House Manager] was talking to [Client #4] about [Client #1's] coffee. She was trying to explain to him about [Client #1] sister said that [Client #1] works hard for his money and she wants him to spend his money on himself and not other client's. That's what [House Manager] was trying to tell him about. Then he got very disrespectful and very angry. So I told him not to disrespect [House Manager]. Then he jumped at me and said what are you going to do and try to run up and fight me. He is a very disrespectful client. Had a hard time calming him down. [House Manager] had to call 911. I have four witnesses that saw what happened." During interview on 10/16/24 the Licensee revealed: -He would ensure the incident reports were completed correctly. This deficiency constitutes a re-cited deficiency	V 367		

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V 367	Continued From page 16 and must be corrected within 30 days.	V 367		
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 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:	V 536	V536: Deficiency: Lack of Training in Alternatives to Restrictive Interventions Immediate Action: Corrective Action: Schedule mandatory training in alternatives to restrictive interventions for the House Manager, Staff #1, Staff #2, and Staff #3 within the next 14 days. Ensure training content includes state-mandated competencies, measurable learning objectives, and Testing. Responsible Staff: Training Coordinator Ensure Competency: Corrective Action: Require staff to demonstrate competency by passing both written and observed behavioral assessments during the training session. Responsible Staff: Certified Trainer in Alternatives to Restrictive Interventions Policy Implementation: Corrective Action: Update the hiring and onboarding process to include: Verification of training in alternatives to restrictive interventions prior to direct care duties. Mandatory training completion within 30 days of hire for all new staff. Will create a spreadsheet in which to track of annual refresher training requirements. Responsible Staff: Human Resources Manager Documentation Improvements: Corrective Action: Implement an electronic tracking system for training records, including expiration dates. Review all staff files to ensure proper documentation of training and correct deficiencies. Responsible Staff: Human Resources Staff and Training Coordinator Training has been arranged with a qualified instructor. Ongoing Monitoring and Refresher Training: Corrective Action: Develop a recurring schedule for annual refresher training for all staff.	

			Provide staff and supervisors with automated reminders of upcoming training deadlines. Responsible Staff: Training Coordinator Compliance Verification Evidence of Correction: Training certificates for the House Manager, Staff #1, [redacted] however, more update training will be complete within 30 days. Staff #2, and Staff #3 are no longer employed with us.. Updated training logs for all staff reflecting compliance with refresher requirements. Long-Term Monitoring: Monthly reviews of training records by Human Resources staff. Quarterly audits by the Program Director to verify adherence to policies and procedures.	

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V 536	Continued From page 17 (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. (1) Documentation shall include: (A) who participated in the training and the outcomes (pass/fail); (B) when and where they attended; and (C) instructor's name; (2) The Division of MH/DD/SAS may review/request this documentation at any time. (i) Instructor Qualifications and Training Requirements: (1) Trainers shall demonstrate competence by scoring 100% on testing in a training program aimed at preventing, reducing and eliminating the	V 536	Training certificates for the House Manager, Staff #1, [redacted] however, more update traing will be complete within 30 days. Staff #2, and Staff #3 are no longer employed with us.. Updated training logs for all staff reflecting compliance with refresher requirements. Long-Term Monitoring: Monthly reviews of training records by Human Resources staff. Quarterly audits by the Program Director to verify adherence to policies and procedures.	

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V 536	Continued From page 18 need for restrictive interventions. (2) Trainers shall demonstrate competence by scoring a passing grade on testing in an instructor training program. (3) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (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: (A) understanding the adult learner; (B) methods for teaching content of the course; (C) methods for evaluating trainee performance; and (D) documentation procedures. (6) Trainers shall have coaching experience teaching a training program aimed at preventing, reducing and eliminating the need for restrictive interventions at least one time, with positive review by the coach. (7) Trainers shall teach a training program aimed at preventing, reducing and eliminating the need for restrictive interventions at least once annually. (8) Trainers shall complete a refresher instructor training at least every two years. (j) Service providers 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 outcomes (pass/fail);	V 536	V536: Deficiency: Lack of Training in Restrictive Interventions Corrective Action: Schedule mandatory training in alternatives to restrictive interventions for the House Manager, Staff #1, Staff #2, and Staff #3 within the next 14 days. Ensure training content includes state-mandated competencies, measurable learning objectives, and testing. Responsible Staff: Training Coordinator Ensure Competency: Corrective Action: Require staff to demonstrate competency by passing both written and observed behavioral assessments during the training session. Responsible Staff: Certified Trainer in Alternatives to Restrictive Interventions Policy Implementation: Corrective Action: Update the hiring and onboarding process to include: Verification of training in alternatives to restrictive interventions prior to direct care duties. Mandatory training completion within 30 days of hire for all new staff. Will create a spreadsheet in which to track of annual refresher training requirements. Responsible Staff: Human Resources Manager Documentation Improvements: Corrective Action: Implement an electronic tracking system for training records, including expiration dates. Review all staff files to ensure proper documentation of training and correct deficiencies. Responsible Staff: Human Resources Staff and Training Coordinator Training has been arranged with a qualified instructor.	

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V 536	Continued From page 19 (B) when and where attended; and (C) instructor's name. (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 competence by completion of coaching or train-the-trainer instruction. (l) Documentation shall be the same preparation as for trainers. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 3 of 4 audited staff (House Manager, #2 and #3) received initial training in alternatives to restrictive interventions and 1 of 4 staff had current	V 536	Ongoing Monitoring and Refresher Training: Corrective Action: Develop a recurring schedule for annual refresher training for all staff. Provide staff and supervisors with automated reminders of upcoming training deadlines. Responsible Staff: Training Coordinator Compliance Verification Evidence of Correction: Training certificates for the House Manager, Staff #1, [redacted] however, more update training will be complete within 30 days. Staff #2, and Staff #3 are no longer employed with us.. Updated training logs for all staff reflecting compliance with refresher	

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V 536	Continued From page 20 interventions expired 06/21/24. Review on 10/16/24 of staff #2's record revealed: -Hire date 06/01/24. -No documentation of current training in alternatives to restrictive interventions. Review on 10/146/24 of staff #3's record revealed: -Hire date not in the record. -No documentation of current training in alternatives to restrictive interventions. During interview on 10/16/24 the Human Resource staff revealed: -Staff #2 was recently hired and she was unable to locate all the paperwork for her file. -She was unsure where the certificates were for the other staff at the time of the exit.	V 536		
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 staff authorized to employ and terminate these procedures are retrained and have demonstrated competence at least annually. (b) Prior to providing direct care to people with disabilities whose treatment/habilitation plan includes restrictive interventions, staff including service providers, employees, students or volunteers shall complete training in the use of	V 537	V537: Deficiency: Lack of Training in Restrictive Interventions Corrective Action: Schedule mandatory restrictive intervention training for the House Manager, Staff #2, and Staff #3 within the next 14 days. Ensure all training is competency-based and meets the requirements outlined in the regulation. Responsible Staff: Training Coordinator and Program Director Completion Date: by 11/30/2024 Ensure Competency: Corrective Action: Conduct post-training evaluations, including written tests and observation-based assessments, to confirm staff competency. Responsible Staff: Certified Trainer in Restrictive Interventions Policy Implementation: Corrective Action: Update the facility#39;s hiring and onboarding process to include: Verification of restrictive intervention training prior to direct care duties. Mandatory completion of restrictive intervention training within 30 days of hire for all new staff. Regular updates to staff training records. Responsible Staff: Human Resources Manager Completion Date: [Insert Completion Date] Documentation Improvements:	

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V 537	Continued From page 21 seclusion, physical restraint and isolation time-out and shall not use these interventions until the training is completed and competence is demonstrated. (c) A prerequisite for taking this training is demonstrating competence by completion of training 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 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 (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 incremental steps in an intervention); (4) strategies for the safe implementation of restrictive interventions; (5) the use of emergency safety interventions which include continuous assessment and monitoring of the physical and psychological well-being of the client and the safe use of restraint throughout the duration of the	V 537	Corrective Action: Implement an electronic record-keeping system to track training records, including expiration dates, to ensure compliance. Conduct a review of all current staff training files to verify the presence of required documentation and correct deficiencies. Responsible Staff: Human Resources Staff and Program Director Ongoing Monitoring and Refresher Training: Corrective Action: Establish a schedule for annual refresher training in restrictive interventions for all staff. Provide automated reminders to staff and supervisors for upcoming training expiration dates. Responsible Staff: Training Coordinator and Program Director Compliance Verification Evidence of Correction: The house manager's previous certificate will be sent from the trainer and a proper update into her file will be made. Training certificates for the House Manager, Staff #2, and Staff #3 indicating completion and competency in restrictive interventions. Updated training logs reflecting compliance for all staff, including refresher training schedules. Long-Term Monitoring: Monthly reviews of training records by Human Resources staff to ensure no lapses occur. Quarterly audits by the Program Director to verify adherence to training policies. The facility will ensure that all corrective actions are implemented and compliance is Anticipated by 12/15/2024 We are committed to maintaining compliance with the regulation and ensuring staff are adequately trained to provide safe and respectful care to clients.	

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	MHL026-857	A. BUILDING: _____ B. WING _____	R 10/16/2024

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V 537	Continued From page 22 restrictive intervention; (6) prohibited procedures; (7) debriefing strategies, including their importance and purpose; and (8) documentation methods/procedures. (h) Service providers shall maintain documentation of initial and refresher training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcomes (pass/fail); (B) when and where they attended; and (C) instructor's name. (2) The Division of MH/DD/SAS may review/request this documentation at any time. (i) Instructor Qualification and Training Requirements: (1) Trainers shall demonstrate competence by scoring 100% on testing in a training program aimed at preventing, reducing and eliminating the need for restrictive interventions. (2) Trainers shall demonstrate competence by scoring 100% on testing in a training program teaching the use of seclusion, physical restraint and isolation time-out. (3) Trainers shall demonstrate competence by scoring a passing grade on testing in an instructor training program. (4) 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 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)(6) of this Rule. (6) Acceptable instructor training programs	V 537		

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V 537	Continued From page 23 shall include, but not be limited to, presentation of: (A) understanding the adult learner; (B) methods for teaching content of the course; (C) evaluation of trainee performance; and (D) documentation procedures. (7) Trainers shall be retrained at least annually and demonstrate competence in the use of seclusion, physical restraint and isolation time-out, as specified in Paragraph (a) of this Rule. (8) Trainers shall be currently trained in CPR. (9) Trainers shall have coaching experience in 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 restrictive interventions at least once annually. (11) Trainers shall complete a refresher instructor training at least every two years. (k) Service providers 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. (2) The Division of MH/DD/SAS may review/request this documentation at any time. (l) 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	V 537		

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V 537	Continued From page 24 competence by completion of coaching or train-the-trainer instruction. (m) Documentation shall be the same preparation for trainers. This Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure 3 of 4 audited staff (House Manager, #2, #3) were trained in restrictive interventions. The findings are: Review on 10/16/24 of the House Manager record revealed: -Hire date of 12/11/23. -No documentation of current training in restrictive interventions. Review on 10/16/24 of staff #1's record revealed: -Hire date 06/26/23. -The training in restrictive interventions expired 06/21/24. Review on 10/16/24 of staff #2's record revealed: -Hire date 06/01/24. -No documentation of current training in restrictive interventions. Review on 10/146/24 of staff #3's record revealed: -Hire date not in the record. -No documentation of current training in restrictive interventions. During interview on 10/16/24 the Human	V 537		

	Resource staff revealed:			

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V 537	Continued From page 25 -Staff #2 was recently hired and she was unable to locate all the paperwork for her file. -She was unsure where the certificates were for the other staff at the time of the exit.	V 537		
V 736	27G .0303(c) Facility and Grounds Maintenance 10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS (c) Each facility and its grounds shall be maintained in a safe, clean, attractive and orderly manner and shall be kept free from offensive odor. This Rule is not met as evidenced by: Based on observation and interviews, the facility was not maintained in a safe manner. The findings are: Observation of the facility on 10/15/24 and 10/16/24 at approximately 10:00am revealed: -2 smoke detectors were beeping throughout the facility. -The smoke detector was beeping in the office and in client #2's bedroom. During interview on 10/15/24 and 10/16/24 the House Manager revealed: -The fire inspector visited the facility and stated the smoke detectors in the facility needed to be replaced and they would replace them for free. -She would get staff #1 to replace the batteries. -Staff #2 changed the batteries on 10/15/24 and the smoke detectors were still beeping. -She would contact the fire inspector about the replacement of the smoke detectors. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 736	V736 Deficiency: Malfunctioning Smoke Detectors Immediate Action: Corrective Action: Contact the local fire inspector to replace all malfunctioning smoke detectors Immediately. Responsible Staff: House Manager and Maintenance Staff Completion Date: New ones has been installed 11/15/2024 Preventative Action: Policy Update: Develop a preventative maintenance schedule to inspect all smoke detectors monthly. Training: Train all staff on the importance of regular checks for fire safety equipment and the procedure for reporting issues immediately. Responsible Staff: House Manager and Program Director Implementation Date: 11/15/2024 Verification of Completion: Action: Conduct a full inspection of all smoke detectors in the facility to ensure functionality. Documentation: Maintain a maintenance log indicating the inspection and replacement of any malfunctioning detectors. Logs will be reviewed weekly by the House Manager. Responsible Staff: Maintenance Staff and House Manager Monitoring: Quarterly safety audits by the Program Director to ensure compliance. Long-Term Monitoring:	

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			Action: Implement a calendar and spreadsheet to track inspection dates and maintenance tasks for fire safety equipment. Responsible Staff: Administrative Assistant The facility will ensure all corrective actions are implemented, and compliance is verified biweekly. We will provide documentation of compliance to the appropriate oversight body upon request and remain committed to maintaining a safe and orderly facility environment for all clients and staff	