



Igniting Hope. Embracing Possibility.

May 1, 2025.

Mental Health Licensure/Certification Section  
NC Division of Health Service Regulation  
2718 Mail Service Center  
Raleigh, NC 27699-2718  
Phone: (919) 855-3795  
Fax: (919) 715-8078

Re: Re-certification Survey Completed 04/09/2025

To Whom It May Concern:

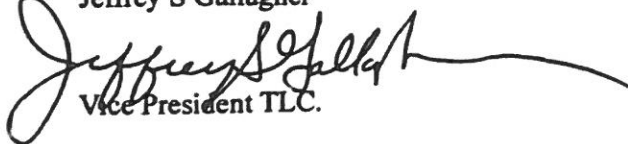
Enclosed please find the Plan of Correction for TLC for our Rose Street Group Home. All survey findings will be back in compliance by June 8, 2025.

We appreciate your efforts to ensure TLC is doing everything possible to provide the best services and support possible to the individuals we serve and their families.

If you have any questions, please do not hesitate to call.

Sincerely,

Jeffrey S Gallagher



Vice President TLC.

Enclosures



nctlc.org

919.832.3909 | info@nctlc.org | 739 Chappell Drive, Raleigh, North Carolina 27606

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  092-267 MHL092-267	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED  04/09/2025
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NAME OF PROVIDER OR SUPPLIER  
**ROSE HOME**

STREET ADDRESS, CITY, STATE, ZIP CODE  
**209 ROSE STREET  
CARY, NC 27611**

(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	<b>INITIAL COMMENTS</b>  An annual and follow up survey was completed on April 9, 2025. Deficiencies were cited.  This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disability.  This facility is licensed for 4 and has a current census of 4. The survey sample consisted of audits of 3 current clients.	V 000		
V 108	<b>27G .0202 (F-I) Personnel Requirements</b>  <b>10A NCAC 27G .0202 PERSONNEL REQUIREMENTS</b> (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 trained to provide cardiopulmonary resuscitation and trained in the Heimlich maneuver or other first aid techniques such as those provided by Red Cross, the American Heart Association or their equivalence for relieving airway obstruction.	V 108	All community residential staff training courses will be reviewed by the training manager on a monthly basis to ensure compliance with standard V 108. The QA specialist will conduct a training session with all supervisors to emphasize the importance of training and adherence to DHSR standards and best practices. We will ensure that the staff member identified in the survey is compliant with her CPR and first aid training by June 8, 2025	6/8/2025

Division of Health Service Regulation

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

TITLE

(X6) DATE

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If continuation sheet 1 of 11

*Jeffrey S. Gallagher* Vice President TLC

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  MHL092-267	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  04/09/2025
NAME OF PROVIDER OR SUPPLIER  ROSE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 209 ROSE STREET CARY, NC 27511		
(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 108	<p>Continued From page 1</p> <p>(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.</p> <p>This Rule is not met as evidenced by: Based on record review, interview and observation, the facility failed to ensure one of three audited staff (#6) had current First Aid training. The findings are:</p> <p>Review on 4/9/25 of staff #6's personnel record revealed: -Hire date was 11/15/10. -She was hired as a Direct Support Professional. -No documentation of current First Aid certification.</p> <p>Interview on 4/9/25 with Staff #6 revealed: -She thought she had completed her first aid training.</p> <p>Observation on 4/9/25 of Staff #6 revealed: -Staff #6 was observed transporting clients to their Day Program.</p> <p>Interview on 4/9/25 with the Quality Assessment/Quality Improvement Specialist revealed: -She thought the staff had completed the training. -She was planning to have an updated first aid training in the next few weeks and would register Staff #6. -She confirmed Staff #6 did not have a current</p>	V 108		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  MHL092-367	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  04/09/2025
NAME OF PROVIDER OR SUPPLIER  ROSE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 209 ROSE STREET CARY, NC 27511		
(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 108	Continued From page 2 first aid training certification.	V 108		
V 118	27G .0209 (C) Medication Requirements  10A NCAC 27G .0209 MEDICATION REQUIREMENTS (c) Medication administration: (1) Prescription or non-prescription drugs shall only be administered to a client on the written order of a person authorized by law to prescribe drugs. (2) Medications shall be self-administered by clients only when authorized in writing by the client's physician. (3) Medications, including injections, shall be administered only by licensed persons, or by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer medications. (4) A Medication Administration Record (MAR) of all drugs administered to each client must be kept current. Medications administered shall be recorded immediately after administration. The MAR is to include the following: (A) client's name; (B) name, strength, and quantity of the drug; (C) instructions for administering the drug; (D) date and time the drug is administered; and (E) name or initials of person administering the drug. (5) Client requests for medication changes or checks shall be recorded and kept with the MAR file followed up by appointment or consultation with a physician.	V 118	The nursing department is set to conduct comprehensive in-service training for all supervisors and staff, focusing on the vital policies and procedures surrounding medication management. This training will emphasize the critical importance of not only distributing medications accurately but also meticulously documenting each administration. In addition, we will implement random monthly reviews of medication practices to ensure adherence to established standards and protocols. For any staff member who fails to comply with medication management guidelines, additional training sessions will be required to reinforce our commitment to maintaining the highest levels of safety and compliance in medication administration.	6/08/2025

Division of Health Service Regulation  
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If continuation sheet 3 of 11



Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(14) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  MHL092-207	(23) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(25) DATE SURVEY COMPLETED  04/09/2025
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

ROSE HOME

209 ROSE STREET  
CARY, NC 27511

(24) 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)	(26) COMPLETE DATE
V 118	<p>Continued From page 3</p> <p>This Rule is not met as evidenced by: Based on observation, record reviews and interview, the facility failed to keep the MARs current affecting two of three audited clients (#1 and #2). The findings are:</p> <p>Review on 4/9/25 of Client #1's record revealed:</p> <ul style="list-style-type: none"> <li>-Admission date of 8/7/2024.</li> <li>-Diagnoses of Cerebral Palsy, Complex Partial Seizures, Spastic Diplegia, Static Encephalopathy, Hypoxic Induced Encephalopathy.</li> <li>-Physician's orders dated 11/20/24: <ul style="list-style-type: none"> <li>-Boost Liquid (Nutritional supplement), give 1 carton of Boost Regular with afternoon snack.</li> </ul> </li> <li>-Physician's order dated 8/17/24: <ul style="list-style-type: none"> <li>-Docusate Sodium softgel 100 milligrams (mg) (Constipation), take one capsule by mouth every morning.</li> <li>-Lamotrigine Extended Release (ER) 50mg (Seizures), take one tablet by mouth every morning (take with 100mg to equal 50mg).</li> <li>-Lamotrigine ER 100mg, take one tablet by mouth every morning (take with 50mg to equal 50mg).</li> <li>-Phillip's Colon Health 3 Billion (3B) cell capsule (Constipation), take one capsule by mouth every morning.</li> <li>-Quetiapine Fumarate 200mg (Schizophrenia and/or Mania, Depression), take one tablet by mouth at bedtime.</li> <li>-Topiramate ER 100mg (Seizures), take five capsules by mouth once daily.</li> <li>-Vitamin B-12 1000 micrograms (mcg) (Vitamin B-12 Deficiency), take two tablets (2000mcg) by mouth once daily.</li> </ul> </li> </ul> <p>Observation on 4/9/25 of Client #1's medications</p>	V 118		

Division of Health Service Regulation  
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If continuation sheet 4 of 11

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  MHL002-267	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  04/09/2026
NAME OF PROVIDER OR SUPPLIER  ROSE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 209 ROSE STREET CARY, NC 27511		
(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 118	<p>Continued From page 4</p> <p>revealed: -All medications listed were available.</p> <p>Review on 4/9/25 of Client #1's MARs from March 1, 2025 through April 9, 2025 revealed: -No staff initials to indicate the medication was administered for the following: -March: -Docusate Sodium 100 mg: 3/10 and 3/24. -Lamotrigine ER 50 mg: 3/10 and 3/24. -Lamotrigine ER 100 mg: 3/10 and 3/24. -Phillip's Colon Health 3B cell: 3/5, 3/10, 3/11, and 3/24. -Topiramate ER 100 mg: 3/23 and 3/30. -Vitamin B-12 1000 mg: 3/10 and 3/24. -Boost Liquid: 3/1-3/7, 3/9-3/29, 3/31. -April: -Boost Liquid: 4/1-4/4, 4/8.</p> <p>Review on 4/9/25 of Client #2's record revealed: -Admission date of 1/27/1997. -Diagnoses of Severe Intellectual/Developmental Disorder, Seizure Disorder. -Physician orders dated 6/12/24: -Marissa 3x28, Outer 0.15-0.03 (Birth Control), 1 tablet by mouth once daily -Polyethylene Glycol 3350 17 grams (GM)/1 dose powder (Constipation), Mix 17 GM into 6-8 ounces of beverage of choice and drink by mouth once daily -Senexon-S 8.6mg-50mg (Constipation), 2 tablets by mouth twice daily -Physician orders dated 9/17/24: -Carbamazepine ER 400mg (Seizures), 1 tablet by mouth twice daily -Culturelle Pro-Well 15 Billion (15B) Cell Cap (Diarrhea), 1 capsule by mouth once daily -Divalproex Sodium 250mg (Seizures), 4 tablets by mouth twice daily -Docusate Sodium 100mg (Constipation), 1</p>	V 118		

Division of Health Service Regulation  
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OVFP11

If continuation sheet 5 of 11

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(R1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  MH1002-397	(R2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(R3) DATE SURVEY COMPLETED  04/09/2025
NAME OF PROVIDER OR SUPPLIER  ROSE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 200 ROSE STREET CARY, NC 27511			
(R4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	(R1) PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS REFERENCED TO THE APPROPRIATE DEFICIENCY)	(R5) COMPLETE DATE	
V 110	<p>Continued From page 5</p> <p>capsule by mouth once daily</p> <ul style="list-style-type: none"> <li>-Gabapentin 300mg (Seizures), 2 capsules by mouth twice daily</li> <li>-Levetiracetam 500mg (Seizures), 2 tablets by mouth twice daily</li> <li>-Vitamin B-6 100mg (Vitamin B-6 Deficiency), 1 tablet by mouth once daily</li> <li>-Vitamin D3 1000u (25mcg) softgel (Vitamin D Deficiency), 1 capsule by mouth once daily</li> </ul> <p>Observation on 4/9/25 of Client #2's medications revealed:</p> <ul style="list-style-type: none"> <li>-All medications listed were available.</li> </ul> <p>Review on 4/9/25 of Client #1's MARs from March 1, 2025 through March 31, 2025 revealed:</p> <ul style="list-style-type: none"> <li>-No staff initials to indicate the medication was administered for the following:</li> <li>-Carbamazepine ER 400mg on 3/20 8:00 am dose and 3/25 8:00 pm dose.</li> <li>-Culturelle Pro-Well 16B on 3/20.</li> <li>-Divalproex Sodium 250mg on 3/20 8:00 am dose.</li> <li>-Docusate Sodium 100mg on 3/20.</li> <li>-Gabapentin 300mg on 3/20 8:00 am dose.</li> <li>-Levetiracetam 500mg on 3/20 8:00 am dose.</li> <li>-Marlissa 3x28, Outer 0.15- 0.03 on 3/20.</li> <li>-Polyethylene Glycol 3350 17G/1 dose powder on 3/20.</li> <li>-Senexon-S 6.6mg-50mg on 3/20.</li> <li>-Vitamin B-6 100mg on 3/20.</li> <li>-Vitamin D3 1000u (25mcg) softgel on 3/20.</li> </ul> <p>Interview with Qualified Professional (QP) on 4/9/25 revealed</p> <ul style="list-style-type: none"> <li>-He was aware that staff did not always initial the MAR after administering medication.</li> <li>-He would get notifications at the end of the month from the nurse regarding which days/doses had not been initiated by staff.</li> </ul>	V 110			

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/CLIA IDENTIFICATION NUMBER  MH1092 207	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  04/09/2025
NAME OF PROVIDER OR ENTITY  ROSE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 209 ROSE STREET CARY, NC 27511		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	(X5) PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETE DATE
V 118	Continued From page 6  -He had staff complete an additional paper copy of the MAR for the missed days/doses in the previous month. -He stated the updating of the MAR had to be done by the 15th of each month. -The March 2025, and April 2025 MARs had not been updated regarding this process yet.  Due to the failure to accurately document medication administration, it could not be determined if the clients received their medication as ordered by the physician.	V 118		
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	All community residential staff training courses will be reviewed by the training manager on a monthly basis to ensure compliance with standard V 536. The QA specialist will conduct a training session with all supervisors to emphasize the importance of training and adherence to DHSR standards and best practices. We will ensure that the staff member identified in the survey is compliant with their NCI training by June 8, 2025	06/08/2025



Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  MHL092-267	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  04/09/2025
NAME OF PROVIDER OR SUPPLIER  ROSE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 209 ROSE STREET CARY, NC 27511		
(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 636	Continued From page 7  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. (1) Documentation shall include:	V 636		

Division of Health Service Regulation  
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If continuation sheet 8 of 11

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  MHL092-267	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  04/09/2025
NAME OF PROVIDER OR SUPPLIER  ROSE HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 209 ROSE STREET CARY, NC 27811		
(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 630	Continued From page 6  (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 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 coached 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	V 630			

If continuation sheet 10 of 11

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  MHL002-267	(2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(3) DATE SURVEY COMPLETED  04/09/2025
NAME OF PROVIDER OR SUPPLIER  ROSE HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 209 ROSE STREET CARY, NC 27511		
(4) 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)	(5) COMPLETE DATE	
V 539	<p>Continued From page 10</p> <p>Review on 4/9/25 of Staff #6's personnel record revealed:</p> <ul style="list-style-type: none"> <li>-Hire date of 11/15/10.</li> <li>-Hired as a Direct Support Professional.</li> <li>-The last training to alternatives to restrictive intervention certification for Staff #6 was dated 4/7/22.</li> <li>-There was no documentation of current training in alternatives to restrictive interventions.</li> </ul> <p>Interview on 4/29/25 with Staff #6 revealed:</p> <ul style="list-style-type: none"> <li>-She was not aware of any of her trainings being expired.</li> </ul> <p>Interview on 4/9/25 with the Quality Assessment/Quality Improvement Specialist revealed:</p> <ul style="list-style-type: none"> <li>-Facility used the North Carolina Intervention Plus (NCI+) curriculum as their training for alternatives to restrictive interventions.</li> <li>-They do not use restrictive interventions.</li> <li>-She was not aware Staff #6's NCI+ training had expired.</li> <li>-Staff #6 would be scheduled to take it at the next available offering of the training. No date was provided for the next available training.</li> <li>-She confirmed Staff #6's training on alternatives to restrictive interventions had expired.</li> </ul> <p>Interview on 4/9/25 with the Qualified Professional revealed:</p> <ul style="list-style-type: none"> <li>-He was not aware that Staff #3's NCI+ training had expired.</li> <li>-He confirmed Staff #6's training on alternatives to restrictive interventions had expired.</li> </ul>	V 539			