

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL088-020	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/04/2010
NAME OF PROVIDER OR SUPPLIER TRAILS CAROLINA		STREET ADDRESS, CITY, STATE, ZIP CODE 500 WINDING GAP ROAD LAKE TOXAWAY, NC 28747		
(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	INITIAL COMMENTS An annual and complaint survey was completed 3/4/10. The complaint was substantiated. (Intake ID #NC00062564). Deficiencies were cited.	V 000		
V 114	27G .0207 Emergency Plans and Supplies 10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES (a) A written fire plan for each facility and area-wide disaster plan shall be developed and shall be approved by the appropriate local authority. (b) The plan shall be made available to all staff 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 fire emergencies. (d) Each facility shall have basic first aid supplies accessible for use. This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to ensure fire and disaster drills were conducted at least once per shift per quarter. The findings are: Review of fire drill records on 3/4/10, from July 2009 through February, 2010, revealed only two documented fire drill during that period, at 1:20 PM on 7/16/09, and at 11:40 AM on 11/30/09, both first shift drills. The record reveals no documentation of fire drills for any other shifts for the 3rd and the 4th quarters of 2009, or for any shift for the 1st quarter of 2010, and no documentation of disaster drills during the past	V 114		

Division of Health Service Regulation

TITLE

(X6) DATE

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

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL088-020	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/04/2010
NAME OF PROVIDER OR SUPPLIER TRAILS CAROLINA		STREET ADDRESS, CITY, STATE, ZIP CODE 500 WINDING GAP ROAD LAKE TOXAWAY, NC 28747		
(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 114	Continued From page 1 year. During interviews with the Executive Director and the Human Resources Manager on 3/4/10, staff acknowledged drills were not being conducted by each shift as often as required. Staff also acknowledged they were unaware of the requirement for conducting disaster drills.	V 114		
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	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL088-020	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/04/2010
NAME OF PROVIDER OR SUPPLIER TRAILS CAROLINA			STREET ADDRESS, CITY, STATE, ZIP CODE 500 WINDING GAP ROAD LAKE TOXAWAY, NC 28747		
(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 2 with a physician.</p> <p>This Rule is not met as evidenced by: Based on record review and interviews, the facility (1) failed to ensure all medications were only administered to a client on the written order of a person authorized by law to prescribe drugs for 4 of 4 client records reviewed (#1, #2, #3, #4) (2) failed to ensure MARs were maintained current for 2 of 4 client records reviewed (#1, #4) The findings are:</p> <p>Review of client records on 2/26/10 revealed Client #1 was admitted to the facility on 12/30/09 with diagnoses of Asperger's Syndrome, Learning Disorder, and Attention Defecit Hyperactivity Disorder.</p> <p>Review on 2/26/10 of Client #1's February 2010 MAR revealed he was administered the following medications: Strattera 40 mg, 1 tab by mouth daily; and a Multivitamin, 1 tab by mouth daily; Azithromycin 250 mg, 1 by mouth daily. Review further revealed no physician's orders were found for the multivitamin and Azithromycin.</p> <p>Review of client records on 2/26/10 revealed Client #2 was admitted to the facility on 12/29/09 with diagnoses of Identity Problem, Generalized Anxiety Disorder, Depressive Disorder, and Alcohol Abuse.</p> <p>Review on 2/26/10 of Client #2's February 2010 MAR revealed he was administered the following medications: Effexor 75 mg, 3 caps by mouth each morning; Yaz 3-0.2 mg, 1 tab by mouth daily, and Trazodone 80 mg, 1/2 or 1 tab by</p>	V 118			

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL088-020	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/04/2010
NAME OF PROVIDER OR SUPPLIER TRAILS CAROLINA		STREET ADDRESS, CITY, STATE, ZIP CODE 500 WINDING GAP ROAD LAKE TOXAWAY, NC 28747		
(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 3</p> <p>mouth at bedtime. Review further revealed no physician's orders were found for the medications listed above.</p> <p>Review of client records on 2/26/10 revealed Client #3 was admitted to the facility on 1/23/10 with diagnoses of Parent Child relational Problems, Sibling Relational Problems, and Oppositional Defiant Disorder.</p> <p>Review on 2/26/10 of Client #3's February 2010 MAR revealed he was administered the following medications: Vyvanse 70 mg 1 capsule by mouth every day; Divalproex ER 500 mg 1 tablet by mouth every evening. Review further revealed no physician's orders were found for the Divalproex.</p> <p>Review of client records on 2/26/10 revealed Client #4 was admitted to the facility on 9/19/09 with diagnoses of Bipolar Disorder, Disruptive Behavior Disorder, and Intermittent Explosive Anger Disorder. Review further revealed, Client #4 graduated from the program on 1/13/10.</p> <p>Review on 2/26/10 of Client #4's January 2010 MAR revealed he was administered the following medications: Multivitamin, 1 tab by mouth daily; Lexapro 10 mg, 1 tab by mouth daily; Focalin 10 mg, 1 tab by mouth daily; and Zyprexa 5 mg, 1 tab by mouth at bedtime. Review further revealed no physician's orders were found for the medications listed above.</p> <p>During interviews with the Field Medic on 3/1/10 and 3/4/10, she acknowledged the facility did not routinely acquire copies of physician's orders.</p> <p>2. Review of client records for Client's #1-4 on 2/26/10 revealed, all medications administered at a specific time (i.e. in the morning) are listed in a</p>	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL088-020	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/04/2010
NAME OF PROVIDER OR SUPPLIER TRAILS CAROLINA		STREET ADDRESS, CITY, STATE, ZIP CODE 500 WINDING GAP ROAD LAKE TOXAWAY, NC 28747		
(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	Continued From page 4 single box in the MAR and all medications are signed with a single set of initials regardless of the number of medications administered. During individual interviews with clients #1-4 on 2/26/10, they stated their medications were administered to them. During interviews with the Field Medic on 3/1/10 and 3/4/10, she acknowledged that staff did not sign off for individual medications which they administered.	V 118		
V 123	27G .0209 (H) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (h) Medication errors. Drug administration errors and significant adverse drug reactions shall be reported immediately to a physician or pharmacist. An entry of the drug administered and the drug reaction shall be properly recorded in the drug record. A client's refusal of a drug shall be charted. . This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to ensure medication errors were reported immediately to a pharmacist or doctor, effecting 3 of 4 clients audited (#1, #2, #4). The findings are: Review of client records on 2/26/10 revealed Client #1 was admitted to the facility on 12/30/09 and was being administered Strattera 40 mg, 1 tab by mouth daily; and a multivitamin, 1 tab by	V 123		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL088-020	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/04/2010
NAME OF PROVIDER OR SUPPLIER TRAILS CAROLINA		STREET ADDRESS, CITY, STATE, ZIP CODE 500 WINDING GAP ROAD LAKE TOXAWAY, NC 28747		
(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 123	Continued From page 5 mouth daily. The review also revealed Client #2 was admitted on 12/29/09 and was being administered Effexor 75 mg, 3 caps by mouth each morning; Yaz 3-0.2 mg, 1 tab by mouth daily, and Trazodone 80 mg, 1/2 or 1 tab by mouth at bedtime. The review further revealed Client #4 was admitted to the facility on 9/19/09, and was being administered a multivitamin, 1 tab by mouth daily; Lexapro 10 mg, 1 tab by mouth daily; Focalin 10 mg, 1 tab by mouth daily; and Zyprexa 5 mg, 1 tab by mouth at bedtime. Review of incident reports on 3/1/10 revealed Client #1 refused his medications on 12/31/09, 1/1/10, and 1/2/10. The review further revealed Client #2 had refused her dose of Effexor 75 mg x3 caps on 12/30/09. The review also revealed Client #4 had refused his morning doses of Lexapro 10 mg, and Focalin 10 mg on 10/17/09, 12/1/09, 12/9/09, 12/12/09, 1/2/10, and 1/4/10, and his night dose of Zyprexa 5 mg, on 10/18/09, 10/24/09, 10/25/09, 12/31/09, and 1/1/10. The review of incident reports also revealed no documentation of these medication errors for Clients #1, #2, and #4 being reported immediately to the pharmacist or client's physician. Interviews with the facility Field Medic on 3/1/09 revealed staff had no recollection of making a call to either the pharmacist or doctor following Client #1, #2, and #4 refusing their medications on the dates listed above. Staff #3 acknowledged either the doctor or pharmacist should have been notified of the medication refusals.	V 123		
V 131	G.S. 131E-256 (D2) HCPR - Prior Employment Verification G.S. §131E-256 HEALTH CARE PERSONNEL	V 131		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL088-020	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/04/2010
NAME OF PROVIDER OR SUPPLIER TRAILS CAROLINA		STREET ADDRESS, CITY, STATE, ZIP CODE 500 WINDING GAP ROAD LAKE TOXAWAY, NC 28747		
(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 131	<p>Continued From page 6</p> <p>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.</p> <p>This Rule is not met as evidenced by: Based on record review and interviews the facility failed to access the NC Division of Facility Services Health Care Personnel Registry (HCPR) to inquire about substantiated findings of abuse, neglect, and/or exploitation by each employee before hiring, as required under G.S.131E-256, for 4 of 5 direct care staff records reviewed (Staff #1 #2,#3, and the Facility Manager). The findings are:</p> <p>Review of personnel files on 3/1/10 revealed Staff #1's hire date was 6/15/09, but Staff #1's HCPR check was not conducted until 11/19/09. Staff #2's hire date was 5/1/09, but this staff's HCPR check was not conducted until 6/15/09. Further review of personnel files revealed Staff #3's hire date was 5/1/09, but this staff's HCPR check was not conducted until 6/11/09. The Facility Manager was hired on 4/1/08, but his HCPR check was not performed until 11/21/08.</p> <p>During interviews with The Executive Director and the Human Resources Manager (HRM) on 3/4/10, staff were asked to locate and produce documentation which would verify the HCPR had been accessed prior to hiring in regard to the above listed staff. Staff was not able to produce</p>	V 131		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL088-020	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/04/2010
NAME OF PROVIDER OR SUPPLIER TRAILS CAROLINA			STREET ADDRESS, CITY, STATE, ZIP CODE 500 WINDING GAP ROAD LAKE TOXAWAY, NC 28747		
(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 131	Continued From page 7 the requested verification for any of the staff listed. The HRM acknowledged they were aware of the requirement to do the HCPR check, but was not aware of the time requirement to complete the checks prior to hire.	V 131			
V 132	G.S. 131E-256(G) HCPR-Notification, Allegations, & Protection G.S. §131E-256 HEALTH CARE PERSONNEL REGISTRY (g) Health care facilities shall ensure that the Department is notified of all allegations against health care personnel, including injuries of unknown source, which appear to be related to any act listed in subdivision (a)(1) of this section. (which includes: a. Neglect or abuse of a resident in a healthcare facility or a person to whom home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided. b. Misappropriation of the property of a resident in a health care facility, as defined in subsection (b) of this section including places where home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided. c. Misappropriation of the property of a healthcare facility. d. Diversion of drugs belonging to a health care facility or to a patient or client. e. Fraud against a health care facility or against a patient or client for whom the employee is providing services). Facilities must have evidence that all alleged acts are investigated and must make every effort to protect residents from harm while the investigation is in progress. The results of all investigations must be reported to the Department within five working days of the initial	V 132			

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL088-020	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/04/2010
NAME OF PROVIDER OR SUPPLIER TRAILS CAROLINA			STREET ADDRESS, CITY, STATE, ZIP CODE 500 WINDING GAP ROAD LAKE TOXAWAY, NC 28747		
(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 132	Continued From page 8 notification to the Department. This Rule is not met as evidenced by: Based on review of records and interviews, the facility failed to ensure that the Health Care Personnel Registry (HCPR) was notified of all allegations against health care personnel. The findings are: Cross refer Tag V 500 10A NCAC 27D .0101(b) (1) Policy on Rights Restrictions and Interventions. The facility failed to implement it's policy and ensure allegations of abuse were reported.	V 132			
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	V 133			

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL088-020	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/04/2010
NAME OF PROVIDER OR SUPPLIER TRAILS CAROLINA		STREET ADDRESS, CITY, STATE, ZIP CODE 500 WINDING GAP ROAD LAKE TOXAWAY, NC 28747		
(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 133	Continued From page 9 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 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	V 133		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL088-020	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/04/2010
NAME OF PROVIDER OR SUPPLIER TRAILS CAROLINA		STREET ADDRESS, CITY, STATE, ZIP CODE 500 WINDING GAP ROAD LAKE TOXAWAY, NC 28747		
(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 133	Continued From page 10 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 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	V 133		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL088-020	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/04/2010
NAME OF PROVIDER OR SUPPLIER TRAILS CAROLINA		STREET ADDRESS, CITY, STATE, ZIP CODE 500 WINDING GAP ROAD LAKE TOXAWAY, NC 28747		
(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 133	Continued From page 11 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 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	V 133		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL088-020	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/04/2010
NAME OF PROVIDER OR SUPPLIER TRAILS CAROLINA		STREET ADDRESS, CITY, STATE, ZIP CODE 500 WINDING GAP ROAD LAKE TOXAWAY, NC 28747		
(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 133	Continued From page 12 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 Public 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		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL088-020	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/04/2010
NAME OF PROVIDER OR SUPPLIER TRAILS CAROLINA		STREET ADDRESS, CITY, STATE, ZIP CODE 500 WINDING GAP ROAD LAKE TOXAWAY, NC 28747		
(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 133	Continued From page 13 This Rule is not met as evidenced by: Based on review of records and interviews, the facility failed to conduct a nation-wide criminal background check on all employees who have not lived in North Carolina for the last 5 years, as required by GS122C-80, Article 3A. The deficient practice was found in 4 of 5 direct care staff records reviewed. (#1, #2, #3 and Facility Manager). The findings are: Review of personnel records of direct care staff on 3/1/10 revealed the files of Staff #1, #2, #3, and the Facility Manager did not contain a nationwide North Carolina State Bureau of Investigation (SBI) criminal background check. The record review further revealed Staff #1 had been hired on 6/15/09 and had resided in Washington State until August, 2005, Staff #2 had been hired on 5/1/09 and had resided in Kansas, Colorado, Idaho and Tennessee within 5 years of hire. Staff #3 was hired 5/1/09, and had resided in Michigan within 5 years of her hire date. The Facility Manager was hired 4/1/08, and had resided in Idaho within 5 years of his hire date. Interviews with the Executive Director and the Human Resources Manager on 3/4/09 revealed the facility Human Resources staff conducts statewide and national criminal background checks using an on-line background check company, but SBI nationwide checks had been neither initiated nor completed for any of the above listed staff .	V 133		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL088-020	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/04/2010
NAME OF PROVIDER OR SUPPLIER TRAILS CAROLINA		STREET ADDRESS, CITY, STATE, ZIP CODE 500 WINDING GAP ROAD LAKE TOXAWAY, NC 28747		
(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 500	Continued From page 14	V 500		
V 500	<p>27D .0101(a-e) Client Rights - Policy on Rights</p> <p>10A NCAC 27D .0101 POLICY ON RIGHTS RESTRICTIONS AND INTERVENTIONS</p> <p>(a) The governing body shall develop policy that assures the implementation of G.S. 122C-59, G.S. 122C-65, and G.S. 122C-66.</p> <p>(b) The governing body shall develop and implement policy to assure that:</p> <p>(1) all instances of alleged or suspected abuse, neglect or exploitation of clients are reported to the County Department of Social Services as specified in G.S. 108A, Article 6 or G.S. 7A, Article 44; and</p> <p>(2) procedures and safeguards are instituted in accordance with sound medical practice when a medication that is known to present serious risk to the client is prescribed. Particular attention shall be given to the use of neuroleptic medications.</p> <p>(c) In addition to those procedures prohibited in 10A NCAC 27E .0102(1), the governing body of each facility shall develop and implement policy that identifies:</p> <p>(1) any restrictive intervention that is prohibited from use within the facility; and</p> <p>(2) in a 24-hour facility, the circumstances under which staff are prohibited from restricting the rights of a client.</p> <p>(d) If the governing body allows the use of restrictive interventions or if, in a 24-hour facility, the restrictions of client rights specified in G.S. 122C-62(b) and (d) are allowed, the policy shall identify:</p> <p>(1) the permitted restrictive interventions or allowed restrictions;</p> <p>(2) the individual responsible for informing the client; and</p> <p>(3) the due process procedures for an involuntary client who refuses the use of</p>	V 500		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL088-020	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/04/2010
NAME OF PROVIDER OR SUPPLIER TRAILS CAROLINA			STREET ADDRESS, CITY, STATE, ZIP CODE 500 WINDING GAP ROAD LAKE TOXAWAY, NC 28747		
(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 500	<p>Continued From page 15</p> <p>restrictive interventions.</p> <p>(e) If restrictive interventions are allowed for use within the facility, the governing body shall develop and implement policy that assures compliance with Subchapter 27E, Section .0100, which includes:</p> <p>(1) the designation of an individual, who has been trained and who has demonstrated competence to use restrictive interventions, to provide written authorization for the use of restrictive interventions when the original order is renewed for up to a total of 24 hours in accordance with the time limits specified in 10A NCAC 27E .0104(e)(10)(E);</p> <p>(2) the designation of an individual to be responsible for reviews of the use of restrictive interventions; and</p> <p>(3) the establishment of a process for appeal for the resolution of any disagreement over the planned use of a restrictive intervention.</p> <p>This Rule is not met as evidenced by: Based on review of facility records, and interviews, the facility failed to implement their policy requiring and ensuring the Department of Social Services (DSS), in the county where services are provided, was notified of all allegations of resident abuse by health care personnel, affecting one of four sampled clients (#4). The findings are:</p> <p>A review of facility records on 3/1/10 revealed an incident report dated 12/23/09 and 2 incident reports dated 12/24/09 addressing a restraint of Client #4 which occurred on 12/23/09. The report by the Facility Manager dated 12/23/09 stated he "restrained (Client #4) to ground and held until staff intervened." The attached Physical</p>	V 500			

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL088-020	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/04/2010
NAME OF PROVIDER OR SUPPLIER TRAILS CAROLINA			STREET ADDRESS, CITY, STATE, ZIP CODE 500 WINDING GAP ROAD LAKE TOXAWAY, NC 28747		
(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 500	<p>Continued From page 16</p> <p>Intervention report also completed by the Facility Manager on 12/23/09 revealed, in the section asking if the student was injured during the intervention, Client #4 got a "bloody lip trying to bite staff."</p> <p>Review on 3/1/10 of the 2 incident reports completed 12/24/09 revealed Staff #1 and Staff #2 witnessed the Facility Manager strike Client #4 during the restraint on 12/23/09. The incident report by Staff #1 revealed he "saw [the Facility Manager] hit [Client #4] in the face ... and observed [Client#4] had blood in his mouth." The incident report by Staff #2 revealed the Facility Manager "took student to ground and punched [Client #4] in the lip."</p> <p>A review on 3/1/10 of an internal investigation report revealed the Executive Director(ED) was out of town and learned of allegations by Client #4 and Staff #1 and #2 in a phone call from the Admissions Director(AD) on 12/23/09. The AD was in charge of facility in the absence of the ED. The AD documented an interview at approximately 4:30 PM on 12/23/09 with Client #4, during which Client #4 told him he had hit the Facility Manager in the face and the Facility Manager hit him back in the face.</p> <p>Review on 3/1/10 of facility policy and procedures for reporting allegations of abuse revealed: " Policy: The therapist shall provide a leadership role in the identification, reporting, and follow-up on child abuse issues. ... Procedures: ...3. The therapist will receive supervision from a clinical supervisor and the Executive Director to determine if there is enough data to warrant a "reasonable suspicion" that a student has been the victim of abuse. That is all that is required for a suspected report. ...</p>	V 500			

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL088-020	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/04/2010
NAME OF PROVIDER OR SUPPLIER TRAILS CAROLINA		STREET ADDRESS, CITY, STATE, ZIP CODE 500 WINDING GAP ROAD LAKE TOXAWAY, NC 28747		
(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 500	<p>Continued From page 17</p> <p>6. c. Documentation will be made on the Abuse, Neglect, and Dependency Report, Attachment 2 and will be forwarded to the Department of Social Services (DSS)."</p> <p>Review of facility records on 3/1/10 revealed no Abuse, Neglect, and Dependency Report, Attachment 2 was on file, nor was there documentation that such a report had been forwarded to DSS.</p> <p>Interviews with Staff #1 and the Facility Manager on 2/26/10, and with Staff #2 on 3/4/10, confirmed that the Facility Manager actively participated in the restraint of Client #4 on 12/23/09, and that Client #4 was injured as a result of the Facility Manager's participation. The Facility manager admitted to punching Client #4 in the face, and both Staff #1 and Staff #2 revealed their belief that the punch was intentional, and not accidental.</p> <p>During interviews with the Executive Director and Human Resources Manager on 2/26/10 and 3/1/10, staff were asked to locate and provide documentation of any in-house investigation or other documentation pertaining to the restraint of Client #4 on 12/23/09. Staff were able to produce incident reports regarding the incident, a summary of the AD's interview with Client #4 on 12/23/09, and a timeline documenting the ED's contacts along with a brief summary of those contacts regarding the 12/23/09 incident. Staff failed to provide verification of an in-house investigation, other than the interview with Client #4, and were unable to produce the Abuse, Neglect, and Dependency Report, Attachment 2. Staff also acknowledged no report had been filed with DSS, nor had a report been filed with the Health Care Personnel Registry.</p>	V 500		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL088-020	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/04/2010
NAME OF PROVIDER OR SUPPLIER TRAILS CAROLINA		STREET ADDRESS, CITY, STATE, ZIP CODE 500 WINDING GAP ROAD LAKE TOXAWAY, NC 28747		
(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 503	<p>27D .0103 Client Rights - Search And Seizure Policy</p> <p>10A NCAC 27D .0103 SEARCH AND SEIZURE POLICY</p> <p>(a) Each client shall be free from unwarranted invasion of privacy.</p> <p>(b) The governing body shall develop and implement policy that specifies the conditions under which searches of the client or his living area may occur, and if permitted, the procedures for seizure of the client's belongings, or property in the possession of the client.</p> <p>(c) Every search or seizure shall be documented. Documentation shall include:</p> <p>(1) scope of search;</p> <p>(2) reason for search;</p> <p>(3) procedures followed in the search;</p> <p>(4) a description of any property seized;</p> <p>and</p> <p>(5) an account of the disposition of seized property.</p> <p>This Rule is not met as evidenced by: Based on record review, policy and procedure review, and interviews , the facility failed to implement their policy that prohibits restricting the rights of a client, using search and seizure, affecting 3 of 4 clients audited (#1-3). The Findings are:</p> <p>Review of G.S. 122C-62 (b) and (d) on 3/1/10 revealed the following: "...(d) except as provided in subsections (e) and (h) of this section, each minor child who is receiving treatment or habilitation in a 24 hour facility has the right to;...</p> <p>(6) except as prohibited by law keep and use personal and possessions under appropriate supervision... (e)...No right enumerated in subsection (b) or (d) of this section may be</p>	V 503		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL088-020	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/04/2010
NAME OF PROVIDER OR SUPPLIER TRAILS CAROLINA		STREET ADDRESS, CITY, STATE, ZIP CODE 500 WINDING GAP ROAD LAKE TOXAWAY, NC 28747		
(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 503	<p>Continued From page 19</p> <p>limited or restricted except by the qualified professional (QP) responsible for the formulation of the child's treatment or habilitation plan. A written statement shall be placed in the client's record that indicated the detailed reason for the restriction. The restriction shall be reasonable and related to the client's treatment or habilitation needs. A restriction is effective for a period not to exceed 30 days. An evaluation of each restriction shall be conducted by the QP at least once every 7 days at which time the restriction may be removed. Each evaluation of a restriction shall be documented in the client's record. Restrictions on rights may be renewed only by a written statement entered by the QP in the client's record that states the reason for the renewal of the restriction."</p> <p>Review of agency search and seizure policy on 3/1/10 revealed, "It is the policy of TRAILS Carolina to protect the privacy of each client. Searches and seizure will only be conducted of client under the following conditions:</p> <ol style="list-style-type: none"> 1. At enrollment to check for contraband and to ensure proper outfitting with the program's gear. ... 2. In the event that the student's group is missing valuables, food, gear, or program tools. ... 3. In an event that a search is warranted to ensure the safety of staff or students. <p>All searches and seizures will be documented in the client file and will include no less than the following: Scope of search, reason for search, procedures followed in search, description of property seized; and account of the disposition of the seized property."</p> <p>Review of client records on 2/26/10 revealed there was no documentation by the QP allowing any of the client's shoes or clothing to be taken.</p>	V 503		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL088-020	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/04/2010
NAME OF PROVIDER OR SUPPLIER TRAILS CAROLINA		STREET ADDRESS, CITY, STATE, ZIP CODE 500 WINDING GAP ROAD LAKE TOXAWAY, NC 28747		
(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 503	Continued From page 20 Review further revealed none of the 3 clients audited had a history of running away. During interviews with Clients #1-3 on 2/26/10, the clients confirmed that their shoes and pants were taken by staff on a nightly basis. During interviews with both direct care staff, and the Executive Director, on 2/26/10, 3/1/10, and 3/4/10 all parties acknowledged that clients shoes and pants were seized each night and returned the following morning. Staff reported this was done to prevent the clients from attempting to run away and that the practice had been standard operating procedure since the facility opened. Interviews further revealed the staff and executive director acknowledged no documentation of these seizures had been completed.	V 503		
V 512	27D .0304 Client Rights - Harm, Abuse, Neglect 10A NCAC 27D .0304 PROTECTION FROM HARM, ABUSE, NEGLECT OR EXPLOITATION (a) Employees shall protect clients from harm, abuse, neglect and exploitation in accordance with G.S. 122C-66. (b) Employees shall not subject a client to any sort of abuse or neglect, as defined in 10A NCAC 27C .0102 of this Chapter. (c) Goods or services shall not be sold to or purchased from a client except through established governing body policy. (d) Employees shall use only that degree of force necessary to repel or secure a violent and aggressive client and which is permitted by governing body policy. The degree of force that is necessary depends upon the individual characteristics of the client (such as age, size and physical and mental health) and the degree	V 512		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL088-020	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/04/2010
NAME OF PROVIDER OR SUPPLIER TRAILS CAROLINA		STREET ADDRESS, CITY, STATE, ZIP CODE 500 WINDING GAP ROAD LAKE TOXAWAY, NC 28747		
(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 512	<p>Continued From page 21</p> <p>of aggressiveness displayed by the client. Use of intervention procedures shall be compliance with Subchapter 10A NCAC 27E of this Chapter.</p> <p>(e) Any violation by an employee of Paragraphs (a) through (d) of this Rule shall be grounds for dismissal of the employee.</p> <p>This Rule is not met as evidenced by: Based on record review and interviews, facility staff failed to protect 1 of 4 clients audited from abuse (#4). The findings are:</p> <p>Review of client records on 2/26/10 revealed Client #4 was admitted to the facility on 9/19/09, with diagnoses of Bipolar Disorder, Disruptive Behavior Disorder, and Intermittent Explosive Anger Disorder. Review further revealed, Client #4 graduated from the program on 1/13/10.</p> <p>Review of staff records on 2/26/10 revealed the Facility Manager was hired 4/1/08. Review further revealed, his Crisis Prevention Intervention (CPI) training was effective 1/10 through 1/11.</p> <p>Review on 2/25/10 of incident reports dated 12/24/09 revealed the following:</p> <p>1) Staff #1's incident report stated: "Client #4 grabbed the rope from Staff #2 and refused to let go. Client #4 then began to kick Staff #2 in the legs, bit and punched him (Staff #2) in the face and body. The Facility Manager attempted to verbally de-escalate Client #4 but was unsuccessful. Client #4 was taken to the ground by the Facility Manager and was assisted by Staff #1 and #2. Client #4 was released and immediately attacked the Facility Manager again. The facility Manager "took student (Client #4) to ground and punched [Client #4] in the lip." Staff</p>	V 512		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL088-020	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/04/2010
NAME OF PROVIDER OR SUPPLIER TRAILS CAROLINA		STREET ADDRESS, CITY, STATE, ZIP CODE 500 WINDING GAP ROAD LAKE TOXAWAY, NC 28747		
(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 512	Continued From page 22 #1 and #2 joined in a hold a second time. Client #4 was released a second time. Client #4 approached the Facility Manager a third time and continued to punch and kick. The Facility Manager attempted verbal de-escalation again and took Client #4 to the ground. Client #4 was released almost immediately." 2) Staff #2's incident report stated: "...Group was dropping near bear hang when [Client #4] refused to give bear rope to staff [Staff #1] and threatened to hit [Staff #1] in the face if he took it. [Staff #1] told student that he needed to take rope. [Client #4] then hit [Staff #1] in the face and continued a physical attack hitting, kicking, and biting [Staff #2]. [Staff #2] used deflection to avoid injury and tried to verbally de-escalate the situation. Staff [Facility Manager] was walking by and tried to verbally de-escalate student [Client #4]. [Client #4] said it was none of [Facility Manager] business and if he didn't leave then he [Client #4] would hit and kick [Facility Manager] was well. [Facility Manager] said he would not leave and that [Client #4] could not hurt staff at which time [Client #4] stopped hitting staff and began to kick and hit staff [Facility Manager]. [Facility Manager] told [Client #4] to stop hitting and kicking and when [Client #4] did not [Facility Manager] layed hands on [Client #4] grabbing his collar and lowering him to the ground. The time was 4:30 PM. Staff [Staff #2] intervened to separate staff and student taking control of student [Client #4's] legs to keep staff [Facility Manager] from getting kicked. [Staff #2] immediately called staff [Staff #1] to take control of [Client #4's] legs to allow him [Staff #2] to control [Client #4's] upper body to release staff [Facility Manager]. Staff [Facility Manager] did not release control so [Staff #2] called for a release.	V 512		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL088-020	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/04/2010
NAME OF PROVIDER OR SUPPLIER TRAILS CAROLINA		STREET ADDRESS, CITY, STATE, ZIP CODE 500 WINDING GAP ROAD LAKE TOXAWAY, NC 28747		
(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 512	<p>Continued From page 23</p> <p>All staff released control. [Client #4] then continued to attack staff [Facility Manager] hitting and kicking. Staff [Staff #2] had called for support on the radio at 4:45 PM. Staff [Facility Manager] grabbed student [Client #4] by the collar of his shirt and quickly lowered him to the ground. Staff [Staff #2] attempted to intervene with staff [Staff #1] when [Staff #2] saw [Facility Manager] hit [Client #4] in the face after being hit by [Client #4]. [Staff #2] took control of [Client #4] with [Staff #1] assisting and observed that [Client #4] had blood in his mouth. Support showed up at this time. All staff released control of [Client #4]. [Client #4] then began to follow staff [Facility Manager] and attempt to assault him. The time was 5:15 PM. [Facility Manager] took [Client #4] by the shirt front again and pushed him to the ground, and then released him..."</p> <p>3) The Facility Manager's incident report dated 12/23/09 reported: "Observed student (Client #4) yelling kicking and punching staff. Went to observe and try to defuse the situation. Client turned on me with verbal, kicking punching and biting." The intervention used included "Restrained to ground and held until staff intervened."</p> <p>Review on 2/25/10 of Facility Managers physical intervention report dated 12/23/09 revealed the following:</p> <p>a) Behavior That Necessitated the Physical Intervention: "Punching and kicking staff-verbal abuse."</p> <p>b) Positive and Less Restrictive Alternatives Used or Considered: "Talking and reasoning."</p> <p>c) What Danger Necessitated the Intervention? "Several punches and kick."</p> <p>d) Precipitating Factors of the Intervention: "Escalated student assaulting 2 staff."</p>	V 512		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL088-020	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/04/2010
NAME OF PROVIDER OR SUPPLIER TRAILS CAROLINA		STREET ADDRESS, CITY, STATE, ZIP CODE 500 WINDING GAP ROAD LAKE TOXAWAY, NC 28747		
(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 512	<p>Continued From page 24</p> <p>e) Was The Student Injured During the Physical Intervention? "Yes. Bloody lip trying to bite staff."</p> <p>f) Description of Plan to Minimize Future Physical Interventions: Minimize contact and ask for support in situations."</p> <p>Review on 2/25/10 of the Director of Admissions investigative report dated 12/23/09 revealed the following: "...According to [Client #4], {Staff #2} was making his life difficult with the bear bag ropes and so he decided to kick him. [Staff #2] asked him to stop and he did not and walked off. [Client #4] reported that [Staff #2] tackled him and was holding him down, so in defense, he began hitting him. [Staff #2] then was holding him down and so [Client #4] continued to kick him and get him to give him the rope. [Facility Manager] came down from cabin 1 and told [Client #4] to stop hitting [Staff #2]. [Client #4] told him (Facility Manager) that it was none of his business and that he would do what he wanted. He (Client #4) kept hitting and punching [Staff #2] and [Facility Manager] intervened and restrained him. [Client #4] reports that when he got back up that he went after [Facility Manager] many times and [Facility Manager] restrained him again. [Staff #2] at this point had his legs. He (client #4) said that he went after [Facility Manager] in frustration and hit him in the face and that [Facility Manager] hit him back in the face."</p> <p>Record review on 2/26/10 revealed, neither a 24 Hour Initial Report nor a 5-Working Day Report to Health Care Personnel Registry (HCPR) had been completed.</p> <p>Interview with Staff #1 on 2/25/10 revealed, there were teeth marks in Client #4's lip. "He bit his lip when he was hit (by the facility manager)."</p>	V 512		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL088-020	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/04/2010
NAME OF PROVIDER OR SUPPLIER TRAILS CAROLINA		STREET ADDRESS, CITY, STATE, ZIP CODE 500 WINDING GAP ROAD LAKE TOXAWAY, NC 28747		
(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 512	<p>Continued From page 25</p> <p>Interview further revealed Client #4's injury was the result of the hit. Interview further revealed, the facility manager did not utilize approved restrictive intervention techniques.</p> <p>Interview with Staff #2 on 3/4/10 revealed, he witnessed the facility manager punch Client #4 in the mouth. "He (facility manager) was pushing him (Client #4) at the same time and popped him, he did not wind up and clock him." Interview further revealed, Client #4 had a bloody lip which was associated with the hit. Interview further revealed, the facility manager did not utilize approved restrictive intervention techniques. "He (facility manager) pushed him (Client #4) down by the shirt...there was force but it wasn't a slam to the ground."</p> <p>Interview with the facility manager on 3/1/10 revealed, "I grabbed him (Client #4) by the shirt and put him down...[Staff #1] and [Staff #2] grabbed his (Client #4) feet. [Staff #1] let go of his (Client #4) right hand and I took one right on the nose. I popped him (Client #4)...light fist on the chin. It's really bothered me ever since, I liked the kid."</p> <p>Client #4 was unable to be interviewed. He was no longer at the facility.</p> <p>Interview with the Executive Director on 2/25/10 revealed, "My understanding is [facility manager] struck [Client #4]. [Facility manager] confirmed this."</p> <p>During interview with the Executive Director on 3/4/10, she acknowledged Client #4's parents were contacted and no other authorities were informed of the incident. Interview further revealed, the facility sought clinical consultation</p>	V 512		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL088-020	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/04/2010
NAME OF PROVIDER OR SUPPLIER TRAILS CAROLINA			STREET ADDRESS, CITY, STATE, ZIP CODE 500 WINDING GAP ROAD LAKE TOXAWAY, NC 28747		
(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 512	Continued From page 26 about the incident and were told it was unnecessary to contact Department of Social Services and HCPR due to it not meeting the criteria for abuse. A protection plan was completed by the facility on 3/4/10, which included the following: "1. All Trails personnel who have any interaction with Trails clients will have restrictive intervention training." "2. All Trails staff whether direct care or support will have training on a typical client profile and types of behaviors to expect." "3. Employee evaluations will include a section on interactions with Trails students." "4. Trails will review with all staff protocols for reporting a staff if they believe that there has been any interaction they deem appropriate or demeaning. Identified staff member will then review the incident and take appropriate disciplinary action." (This deficiency constitutes a Type B rule violation. An administrative penalty of \$200.00 is per day will be imposed for failure to correct within 45 days.)	V 512			
V 522	27E .0104(e10) Client Rights - Sec. Rest. & ITO 10A NCAC 27E .0104 SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT AND PROTECTIVE DEVICES USED FOR BEHAVIORAL CONTROL (e) Within a facility where restrictive interventions may be used, the policy and procedures shall be in accordance with the following provisions: (10) The emergency use of restrictive interventions shall be limited, as follows: (A) a facility employee approved to administer emergency interventions may employ such	V 522			

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL088-020	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/04/2010
NAME OF PROVIDER OR SUPPLIER TRAILS CAROLINA		STREET ADDRESS, CITY, STATE, ZIP CODE 500 WINDING GAP ROAD LAKE TOXAWAY, NC 28747		
(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 522	<p>Continued From page 27</p> <p>procedures for up to 15 minutes without further authorization;</p> <p>(B) the continued use of such interventions shall be authorized only by the responsible professional or another qualified professional who is approved to use and to authorize the use of the restrictive intervention based on experience and training;</p> <p>(C) the responsible professional shall meet with and conduct an assessment that includes the physical and psychological well-being of the client and write a continuation authorization as soon as possible after the time of initial employment of the intervention. If the responsible professional or a qualified professional is not immediately available to conduct an assessment of the client, but concurs that the intervention is justified after discussion with the facility employee, continuation of the intervention may be verbally authorized until an on-site assessment of the client can be made;</p> <p>(D) a verbal authorization shall not exceed three hours after the time of initial employment of the intervention; and</p> <p>(E) each written order for seclusion, physical restraint or isolation time-out is limited to four hours for adult clients; two hours for children and adolescent clients ages nine to 17; or one hour for clients under the age of nine. The original order shall only be renewed in accordance with these limits or up to a total of 24 hours.</p> <p>This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to ensure interventions exceeding 15 minutes were authorized only by the responsible professional or another qualified professional who is approved to use and to authorize the use of the restrictive intervention based on experience and</p>	V 522		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL088-020	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/04/2010
NAME OF PROVIDER OR SUPPLIER TRAILS CAROLINA			STREET ADDRESS, CITY, STATE, ZIP CODE 500 WINDING GAP ROAD LAKE TOXAWAY, NC 28747		
(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 522	Continued From page 28 training, effecting 1 of 4 clients audited (#4). The findings are: Review of Physical Restraint Reports on 3/1/10 revealed the following physical restraints of Client #4 which exceeded 15 minutes: 9/19/09 at 7:30 PM for 30 minutes 9/20/09 at 4:00 PM for 30 minutes 9/20/09 at 5:50 PM for 48 minutes 9/22/09 at 8:30 PM for 45 minutes 9/23/09 at 12:15 PM for 30 minutes 9/23/09 at 1:00 PM for 30 minutes 9/29/09 at 4:10 PM for 20 minutes 1/15/10 at 5:11 PM for 28 minutes, and 34 seconds. The review further revealed no documentation on the Physical Restraint Reports or on file elsewhere of authorization for restraints lasting longer than 15 minutes by the responsible professional (QP) or another qualified professional who is approved to use and to authorize the use of the restrictive intervention based on experience and training. During interview with the Executive Director (ED) on 3/4/10, The ED was asked to locate and produce verification of authorization by a QP for physical restraints exceeding 15 minutes in length. She was unable to provide the requested verification. The ED acknowledged that staff were not seeking authorization from the QP for extended restraints.	V 522			
V 537	27E .0108 Client Rights - Training in Sec Rest & ITO 10A NCAC 27E .0108 TRAINING IN SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT	V 537			

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL088-020	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/04/2010
NAME OF PROVIDER OR SUPPLIER TRAILS CAROLINA		STREET ADDRESS, CITY, STATE, ZIP CODE 500 WINDING GAP ROAD LAKE TOXAWAY, NC 28747		
(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 537	Continued From page 29 (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 seclusion, physical restraint and isolation time-out and shall not use these interventions until the training is completed and competence is demonstrated. (c) A pre-requisite 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	V 537		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL088-020	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/04/2010
NAME OF PROVIDER OR SUPPLIER TRAILS CAROLINA		STREET ADDRESS, CITY, STATE, ZIP CODE 500 WINDING GAP ROAD LAKE TOXAWAY, NC 28747		
(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 537	Continued From page 30 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 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.	V 537		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL088-020	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/04/2010
NAME OF PROVIDER OR SUPPLIER TRAILS CAROLINA		STREET ADDRESS, CITY, STATE, ZIP CODE 500 WINDING GAP ROAD LAKE TOXAWAY, NC 28747		
(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 537	Continued From page 31 (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 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 coached 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);	V 537		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL088-020	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/04/2010
NAME OF PROVIDER OR SUPPLIER TRAILS CAROLINA		STREET ADDRESS, CITY, STATE, ZIP CODE 500 WINDING GAP ROAD LAKE TOXAWAY, NC 28747		
(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 537	<p>Continued From page 32</p> <p>(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 competence by completion of coaching or train-the-trainer instruction. (m) Documentation shall be the same preparation as for trainers.</p> <p>This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to ensure physical restraint was employed only by staff who had been trained and had demonstrated competence in the proper use of and alternatives to these procedures, and were retrained and had demonstrated competence at least annually, effecting 1 of 4 client's audited (#4). The findings are.</p> <p>A review of policy and procedures on 2/26/10 revealed the facility staff utilize the Crisis Prevention Intervention (CPI) system for employing physical restraints, and that physical restraints may be employed on an emergency basis, when a client provides a danger to himself or others, and inflicts significant property damage.</p> <p>A review of incident reports on 3/1/10 revealed 3 incident reports describing the Facility Manager taking Client #4 to the ground twice during a</p>	V 537		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL088-020	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/04/2010
NAME OF PROVIDER OR SUPPLIER TRAILS CAROLINA			STREET ADDRESS, CITY, STATE, ZIP CODE 500 WINDING GAP ROAD LAKE TOXAWAY, NC 28747		
(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 537	<p>Continued From page 33</p> <p>single incident at approximately 4:30 PM on 12/23/09. Client #4 received a cut in his mouth as a result of a punch by the Facility Manager during the physical restraint. Further review of the incident reports also revealed the Facility Manager took the client down by "grabbing his collar and lowering him to the ground."</p> <p>A review of staff personnel records on 3/1/10 revealed no evidence on file that the facility manager had participated and demonstrated competence in CPI Training between his hire date of 4/1/08 and January, 2010.</p> <p>During interviews with staff conducted on 2/26/10 and 3/4/10, administrative staff were asked to locate and provide verification of training within a year prior to the 12/23/09 incident in CPI for the Facility Manager. Staff were unable to produce verification of the required training for the Facility Manager.</p> <p>Interviews with Staff #1 and the Facility Manager on 2/26/10, and with Staff #2 on 3/4/10, confirmed that the Facility Manager actively participated in the restraint of Client #4 on 12/23/09, and that Client #4 was injured as a result of the Facility Manager's participation. The interview with the Facility Manager on 2/26/10 also revealed that the Facility Manager had received NCI training from a previous employer, but he was not current in any kind of restraint training at the time of the incident.</p>	V 537			