Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL001-233	A. BUILDING: ______ B. WING ______	R 09/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARNER'S HOUSE OF GRACE	**914 DIXIE STREET BURLINGTON, NC 27217**

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V 000	INITIAL COMMENTS An annual, complaint and follow up survey was completed on 9/12/18. The complaint was substantiated (intake #NC00142732). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities.	V 000		
V 112	27G .0205 (C-D) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (c) The plan shall be developed based on the assessment, and in partnership with the client or legally responsible person or both, within 30 days of admission for clients who are expected to receive services beyond 30 days. (d) The plan shall include: (1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement; (2) strategies; (3) staff responsible; (4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both; (5) basis for evaluation or assessment of outcome achievement; and (6) written consent or agreement by the client or responsible party, or a written statement by the provider stating why such consent could not be obtained.	V 112		

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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V 112	Continued From page 1 This Rule is not met as evidenced by: Based on record review and interviews the facility failed to develop and implement strategies to address the needs and behaviors of a client affecting one of three current clients (#1). The findings are: Review on 9/11/18 of client # 1's record revealed: -Admission date of 7/6/17. -Diagnoses of Mild Intellectual Disability and Bipolar II Disorder. -Person Centered Plan dated 7/17/18 had no strategies to address elopement, suicidal ideation's and homicidal ideation's. Review of facility records on 9/12/18 revealed: -Incident reports for client #1 had the following information: (1). 9/6/18-"[Client #1] eloped from the facility on foot. Staff called [the local police department] to file an incident and have them search the area. Officers responded and brought [client #1] back to the home. Upon arrival [client #1] made claims to harm staff, conumers (consumers) or herself if she had to stay at the home. Officers called the hospital to have her committed but they did not have any beds available and asked the officers to find an alternative solution. Officers discussed with [client #1] that she needed to go back into the home and they had no reason to take her to the hospital. [Client #1] came into the home and became aggressive and destructive. She refused to allow staff to search her belongings or turn them in for the night. When [the Home Manager] went into her room [client #1] kicked [the Home Manager] and hit [client #1] and yelled that she was not staying at the home and she was going	V 112		

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V 112	Continued From page 2	V 112		

to end up burning the house down. Staff called [the local police department], who dispatched officers back out to the home. Officers tried to calm [client #1], but she was kicking the doors at the home and yelling and screaming at them. At that time [client #1] was taken to jail."

(2). 8/23/18- "[Client #1] stated to [Mental Health Agency] staff member that she was cutting herself, had suicide ideation's as well as homicidal ideation's. [Client #1] showed [Mental Health Agency] staff where she allegedly cut herself in the stomach with a broken bottle from the street and had apparent marks on her forehead. [Client #1] did not discuss where these actions took place. These allegations were unknown to group home staff at the time of this incident; however a roommate discussed concerns with staff on August 6th about the consumer cutting her wrists, but staff found no evident scars and contacted [client #1's] guardian regarding what the roommate had reported. [Client #1] was taken to the [Mental Health Agency] crisis center 8/22/2018 where she was IVC'd (involuntarily committed) to the nearest Emergency Room. A psychiatric evaluation was completed on [client #1] and she was discharged from the hospital the same night. [Client #1] still has not expressed any harmful ideation's to the group home staff."

Review of records on 9/11/18 for client #1 revealed:
-A Discharge Summary from local hospital dated 8/30/18 had the following information: Client #1 was admitted to the hospital on 8/25/18 due to suicidal and homicidal ideation's. Client #1 was discharged on 8/30/18.

Client #1 was not available for interview because

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V 112	Continued From page 3 she was incarcerated. Interview on 9/11/18 with staff #1 revealed: -She witnessed the most recent incident with client #1 and the Home Manager. -Client #1 got upset with the Home Manager because she asked for her cell phone. -Client #1 swung at the Home Manager and kicked the Home Manager's arm. -Client #1 had just returned to the group home prior to that incident. -Client #1 had eloped earlier and the police brought her back to the group home. -She called the police department again because she felt like client #1 was getting out of control. -Client #1 had threatened to "kill" everyone in the group home at least once. -She confirmed client #1 had no strategies to address elopement, suicidal ideation's and homicidal ideation's. Interview on 9/11/18 and 9/12/18 with the Home Manager revealed: -Client #1 had a recent incident with staff. -Client #1 was arrested during that incident due to assault and property damage. -Client #1 swung at her and kicked her lower body. -Client #1 also kicked the back door at the group home. -Client #1 also threatened to harm everyone in the group home during that incident. -Staff #1 called the police department to report the incident. -Client #1 had eloped from the group home earlier that day. -The police brought her back to the home. -Staff #1 had to call the police a second time that day. -She thought client #1 eloped from the group two	V 112		

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V 112	Continued From page 4 or three times. -Each time client #1 eloped staff called the police department. -She thought client #1 went to the hospital twice for suicidal and/or homicidal ideation's. -The first time she went to the hospital in August 2018 they did not keep her overnight. -During the second hospital visit in August 2018 client #1 was in the hospital for about a week. -She confirmed client #1 had no strategies to address elopement, suicidal ideation's and homicidal ideation's. Interview on 9/11/18 with the Licensee/Qualified Professional revealed: -Client #1 had some recent issues with elopement, suicidal ideation's and homicidal ideation's. -She noticed client #1's behaviors were getting worst over the last month. -She felt like client #1's behaviors were getting worst because she was informed of a change in guardianship. -Client #1 was informed she was possibly going to be her own guardian. -Client #1 was just recently arrested and was in jail. -Client #1 was arrested for assault and property damage. -Client #1 assaulted the Home Manager. -Client #1 was upset because the Home Manager asked for her cell phone. -Staff had to call the police department and client #1 was arrested. -She thought client #1 eloped from the home about three times. -Staff called the police department each time client #1 eloped. -The police officers would normally find client #1 at a park in the community.	V 112		

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V 112	Continued From page 5 -She thought client #1 went to the hospital twice for suicidal and/or homicidal ideation's. -The first time she went to the hospital they did not keep her overnight. -During the second hospital visit client #1 was in the hospital for almost a week. -She thought client #1 threatened to harm herself once. -If client #1 was upset she would threaten to harm everyone in the group home. -Client #1 made verbal threats on several occasions. -She confirmed client #1 had no strategies to address elopement, suicidal ideation's and homicidal ideation's. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 112		
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.	V 114		

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V 114	Continued From page 6	V 114		

This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to conduct fire and disaster drills under conditions that simulate emergencies at least quarterly and repeated for each shift. The findings are:

Record review on 9/12/18 of the facility's fire drill log revealed the following:
-9/17/18- 10:00 PM
-8/19/18- 4:30 PM
-8/16/18- 3:30 PM
-7/24/18-9:15 AM
-11/21/17-9:30 AM
-There were no fire drills completed during the 1st and 2nd quarters of 2018.

Record review on 9/12/18 of the facility's disaster drill log revealed the following:
-9/6/18-8:30 AM
-6/5/18- 8:00 PM
-3/8/18-3:00 PM
-11/12/17-10:00 AM
-There was only one disaster drill completed during the 2nd quarter of 2018.
-There was only one disaster drill completed during the 1st quarter of 2018.

Interview with client #2 on 9/11/18 revealed:
-They did fire and disaster drills with staff.
-There were no specific times that drills were conducted.

Interview with client #3 on 9/11/18 revealed:
-Staff did fire and disaster drills with them.
-She was not sure how often the drills were conducted.

Interview with the Home Manager on 9/12/18 revealed:

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V 114	Continued From page 7 -The group home had two separate shifts. -Group Home staff worked two twelve hour shifts. -She was not aware staff were not doing the fire and disaster drills for both shifts. -She confirmed staff failed to conduct fire and disaster drills under conditions that simulate emergencies.	V 114		
V 500	27D .0101(a-e) Client Rights - Policy on Rights 10A NCAC 27D .0101 POLICY ON RIGHTS RESTRICTIONS AND INTERVENTIONS (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. (b) The governing body shall develop and implement policy to assure that: (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 (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. (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: (1) any restrictive intervention that is prohibited from use within the facility; and (2) in a 24-hour facility, the circumstances under which staff are prohibited from restricting the rights of a client. (d) If the governing body allows the use of restrictive interventions or if, in a 24-hour facility,	V 500		

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V 500	Continued From page 8	V 500		

the restrictions of client rights specified in G.S. 122C-62(b) and (d) are allowed, the policy shall identify:
(1) the permitted restrictive interventions or allowed restrictions;
(2) the individual responsible for informing the client; and
(3) the due process procedures for an involuntary client who refuses the use of restrictive interventions.
(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:
(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);
(2) the designation of an individual to be responsible for reviews of the use of restrictive interventions; and
(3) the establishment of a process for appeal for the resolution of any disagreement over the planned use of a restrictive intervention.

This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to ensure client rights as specified in G.S. 122C-62(b) and (d) clients' right to free access to personal belongings affecting two of five current clients (#2 and #4). The findings are:

Review on 9/12/18 of General Statue 122C-62

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V 500	Continued From page 9	V 500		

revealed "A written statement shall be placed in the client's record that indicates 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 qualified professional at least every seven days, at which time the restriction may be removed. Each evaluation of a restriction shall be documented in the client's records."

a. Review on 911/18 of client #2's record revealed:
-Admission date of 1/24/14.
-Diagnoses of Mental Retardation, Depression, Galactosemia, Allergic Rhinitis and Headaches.
-There was no evidence of a written statement for client #2 detailing restrictions of personal possessions or evidence of an evaluation of each restriction reviewed at least every seven days.

b. Review on 9/11/18 of client #4's record revealed:
-Admission date of 9/19/16.
-Diagnoses of Mild Mental Retardation, Schizoaffective Disorder, Onychomycosis and Impacted Cerumen.
-There was no evidence of a written statement for client #4 detailing restrictions of personal possessions or evidence of an evaluation of each restriction reviewed at least every seven days.

Interview on 9/11/18 with client #2 revealed:
-Staff take their cell phones and other electronics.
-Staff took those items every night at 8 PM.
-Staff had been taking those items since she moved into the home.

Interview on 9/11/18 with client #4 revealed:

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V 500	Continued From page 10 -They were required to give staff their cell phones and electronics. -She had a radio and had to give it to staff every night at 8:00 PM. -Staff never told her why she had to give them her radio each night. Interview with staff #1 on 9/11/18 revealed: -The clients are required to give staff their cell phones and electronics at night. -Each client had to give staff their cell phone and/or electronics at 8:00 PM. -She had been employed for about a year with the home. -That was always a rule for clients to give staff their cell phones and electronics. Interview with the Home Manager on 9/12/18 revealed: -Staff were required to take client's cell phones and/or electronics. -Staff would normally collect the client's cell phones and/or electronics daily. -The clients were required to turn in their cell phones and/or electronics at 8:00 PM -They had been taking client's cell phones and/or electronics for several years. -They had been taking client's cell phones and/or electronics due to past incidents. -A few years ago a client called 911 with their cell phone. -There was also a client making calls to a person they wanted to visit the group home. -She did not realize taking client's cell phones and/or electronics was considered a rights restriction.	V 500		
V 536	27E .0107 Client Rights - Training on Alt to Rest. Int.	V 536		

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V 536	Continued From page 11 10A NCAC 27E .0107 TRAINING ON ALTERNATIVES TO RESTRICTIVE INTERVENTIONS (a) Facilities shall implement policies and practices that emphasize the use of alternatives to restrictive interventions. (b) Prior to providing services to people with disabilities, staff including service providers, employees, students or volunteers, shall demonstrate competence by successfully completing training in communication skills and other strategies for creating an environment in which the likelihood of imminent danger of abuse or injury to a person with disabilities or others or property damage is prevented. (c) Provider agencies shall establish training based on state competencies, monitor for internal compliance and demonstrate they acted on data gathered. (d) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (e) Formal refresher training must be completed by each service provider periodically (minimum annually). (f) Content of the training that the service provider wishes to employ must be approved by the Division of MH/DD/SAS pursuant to Paragraph (g) of this Rule. (g) Staff shall demonstrate competence in the following core areas: (1) knowledge and understanding of the people being served; (2) recognizing and interpreting human behavior;	V 536		

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V 536	Continued From page 12 (3) recognizing the effect of internal and external stressors that may affect people with disabilities; (4) strategies for building positive relationships with persons with disabilities; (5) recognizing cultural, environmental and organizational factors that may affect people with disabilities; (6) recognizing the importance of and assisting in the person's involvement in making decisions about their life; (7) skills in assessing individual risk for escalating behavior; (8) communication strategies for defusing and de-escalating potentially dangerous behavior; and (9) positive behavioral supports (providing means for people with disabilities to choose activities which directly oppose or replace behaviors which are unsafe). (h) Service providers shall maintain documentation of initial and refresher training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcomes (pass/fail); (B) when and where they attended; and (C) instructor's name; (2) The Division of MH/DD/SAS may review/request this documentation at any time. (i) Instructor Qualifications and Training Requirements: (1) Trainers shall demonstrate competence by scoring 100% on testing in a training program aimed at preventing, reducing and eliminating the need for restrictive interventions. (2) Trainers shall demonstrate competence by scoring a passing grade on testing in an instructor training program.	V 536		

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V 536	Continued From page 13 (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 aimed at preventing, reducing and eliminating the need for restrictive interventions at least once annually. (8) Trainers shall complete a refresher instructor training at least every two years. (j) Service providers shall maintain documentation of initial and refresher instructor training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcomes (pass/fail); (B) when and where attended; and (C) instructor's name. (2) The Division of MH/DD/SAS may request and review this documentation any time.	V 536		

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	MHL001-233	A. BUILDING: ______ B. WING ______	R 09/12/2018

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(k) Qualifications of Coaches:
(1) Coaches shall meet all preparation requirements as a trainer.
(2) Coaches shall teach at least three times the course which is being coached.
(3) Coaches shall demonstrate competence by completion of coaching or train-the-trainer instruction.
(l) Documentation shall be the same preparation as for trainers.

This Rule is not met as evidenced by:
Based on record reviews and interview, the facility failed to ensure one of four audited staff (staff #2) had training on the use of alternatives to restrictive interventions prior to providing services and failed to ensure three of four audited staff (staff #1, the Home Manager and Licensee/Qualified Professional) had current training on the use of alternatives to restrictive interventions. The findings are:

1. The following is evidence the facility failed to have training on the use of alternatives to restrictive interventions prior to providing services.

Review on 9/12/18 of the facility's personnel files revealed:
-Staff #2 had a hire date of 1/19/16.
-Staff #2 was hired as a Paraprofessional.
-There was no documentation that staff #2 had training on the use of alternatives to restrictive interventions.

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V 536	Continued From page 15 2. The following is evidence the facility failed to ensure staff had current training on the use of alternatives to restrictive interventions. a. Review on 9/12/18 of the facility's personnel files revealed: -Staff #1 had a hire date of 10/9/17. -Staff #1 was hired as a Paraprofessional. -Staff #1 had North Carolina Intervention training that expired 4/27/18. -There was no documentation that staff #1 had current training on the use of alternatives to restrictive interventions. b. Review on 9/12/18 of the facility's personnel files revealed: -The Home Manager had a hire date of 8/1/13. -The Home Manager had North Carolina Intervention training that expired 6/27/18. -There was no documentation that the Home Manager had current training on the use of alternatives to restrictive interventions. c. Review on 9/12/18 of the facility's personnel files revealed: -The Licensee/Qualified Professional had a hire date of 8/1/13. -The Licensee/Qualified Professional had a training in North Carolina Interventions that expired 6/27/18. -There was no documentation that the Licensee/Qualified Professional had current training on the use of alternatives to restrictive interventions. Interview with the Home Manager on 9/12/18 revealed: -The agency uses North Carolina Interventions training on the use of alternative to restrictive intervention.	V 536		

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V 536	Continued From page 16 -She did not realize staff #2 had no training in North Carolina Interventions prior to hire. -She was aware that the other staff North Carolina Interventions training had expired. -They were all scheduled to do the North Carolina Interventions training last week. -The North Carolina Interventions trainer canceled the class. -She confirmed staff #2 had no training on the use of alternatives to restrictive interventions prior to providing services. -She confirmed staff #1 and the Licensee/Qualified Professional had no current training on the use of alternatives to restrictive interventions. -She also confirmed she had no current training on the use of alternatives to restrictive interventions.	V 536		
V 537	27E .0108 Client Rights - Training in Sec Rest & ITO 10A NCAC 27E .0108 TRAINING IN SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT (a) Seclusion, physical restraint and isolation time-out may be employed only by staff who have been trained and have demonstrated competence in the proper use of and alternatives to these procedures. Facilities shall ensure that staff authorized to employ and terminate these procedures are retrained and have demonstrated competence at least annually. (b) Prior to providing direct care to people with disabilities whose treatment/habilitation plan includes restrictive interventions, staff including service providers, employees, students or volunteers shall complete training in the use of seclusion, physical restraint and isolation time-out	V 537		

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V 537	Continued From page 17 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 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;	V 537		

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V 537	Continued From page 18 (6) prohibited procedures; (7) debriefing strategies, including their importance and purpose; and (8) documentation methods/procedures. (h) Service providers shall maintain documentation of initial and refresher training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcomes (pass/fail); (B) when and where they attended; and (C) instructor's name. (2) The Division of MH/DD/SAS may review/request this documentation at any time. (i) Instructor Qualification and Training Requirements: (1) Trainers shall demonstrate competence by scoring 100% on testing in a training program aimed at preventing, reducing and eliminating the need for restrictive interventions. (2) Trainers shall demonstrate competence by scoring 100% on testing in a training program teaching the use of seclusion, physical restraint and isolation time-out. (3) Trainers shall demonstrate competence by scoring a passing grade on testing in an instructor training program. (4) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (5) The content of the instructor training the service provider plans to employ shall be approved by the Division of MH/DD/SAS pursuant to Subparagraph (j)(6) of this Rule. (6) Acceptable instructor training programs shall include, but not be limited to, presentation	V 537		

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V 537	Continued From page 19 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); (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	V 537		

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train-the-trainer instruction.
(m) Documentation shall be the same preparation as for trainers.

This Rule is not met as evidenced by:
Based on record reviews and interview, the facility failed to ensure one of four audited staff (staff #2) had training in the use of seclusion, physical restraints and isolation time-out prior to hire and the facility failed to ensure three of four audited staff (staff #1, the Home Manager and Licensee/Qualified Professional) had current training in the use of seclusion, physical restraints and isolation time-out. The findings are:

1. The following is evidence the facility failed to have training in the use of seclusion, physical restraints and isolation time-out prior to hire.

Review on 9/12/18 of the facility's personnel files revealed:
-Staff #2 had a hire date of 1/19/16.
-Staff #2 was hired as a Paraprofessional.
-There was no documentation that staff #2 had training in the use of seclusion, physical restraints and isolation time-out.

2. The following is evidence the facility failed to ensure staff had current training in the use of seclusion, physical restraints and isolation time-out.

a. Review on 9/12/18 of the facility's personnel files revealed:
-Staff #1 had a hire date of 10/9/17.
-Staff #1 was hired as a Paraprofessional.
-Staff #1 had North Carolina Intervention training

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that expired 4/27/18.
-There was no documentation that staff #1 had current training in the use of seclusion, physical restraints and isolation time-out.

b. Review on 9/12/18 of the facility's personnel files revealed:
-The Home Manager had a hire date of 8/1/13.
-The Home Manager had North Carolina Intervention training that expired 6/27/18.
-There was no documentation that the Home Manager had current training in the use of seclusion, physical restraints and isolation time-out.

c. Review on 9/12/18 of the facility's personnel files revealed:
-The Licensee/Qualified Professional had a hire date of 8/1/13.
-The Licensee/Qualified Professional had a training in North Carolina Interventions that expired 6/27/18.
-There was no documentation that the Licensee/Qualified Professional had current training in the use of seclusion, physical restraints and isolation time-out.

Interview with the Home Manager on 9/12/18 revealed:
-The agency uses North Carolina Interventions training in the use of seclusion, physical restraints and isolation time-out.
-She did not realize staff #2 had no training in North Carolina Interventions prior to hire.
-She was aware that other staff North Carolina Interventions training had expired.
-They were all scheduled to do the North Carolina Interventions training last week.
-The North Carolina Interventions trainer canceled the class.

Division of Health Service Regulation

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V 537	Continued From page 22 -She confirmed staff #2 had no training in the use of seclusion, physical restraints and isolation time-out prior to providing services. -She confirmed staff #1 and the Licensee/Qualified Professional had no current training in the use of seclusion, physical restraints and isolation time-out. -She also confirmed she had no current training in the use of seclusion, physical restraints and isolation time-out.	V 537		