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| SOUTHLIGHT HEALTHCARE-GARNER ROAD | 2101 GARNER ROAD RALEIGH, NC 27610 |

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| V 000 | INITIAL COMMENTS<br><br>An Annual, Complaint and Follow Up Survey was completed March 1, 2019. The death complaint was unsubstantiated (Intake #NC00145384). Deficiencies were cited.<br><br>This facility is licensed for the following service categories:<br>10A NCAC 27G .3600 Outpatient Opioid Treatment;<br>10A NCAC 27G .3700 Day Treatment Facilities for Individuals with Substance Abuse Disorders;<br>10A NCAC 27G .4400 Substance Abuse Intensive Outpatient Program (SAIOP).<br><br>The census of this facility is 535. | V 000 | DHSR - Mental Health<br>MAR 26 2019<br>Lic. & Cert. Section | |
| V 105 | 27G .0201 (A) (1-7) Governing Body Policies<br><br>10A NCAC 27G .0201 GOVERNING BODY POLICIES<br>(a) The governing body responsible for each facility or service shall develop and implement written policies for the following:<br>(1) delegation of management authority for the operation of the facility and services;<br>(2) criteria for admission;<br>(3) criteria for discharge;<br>(4) admission assessments, including:<br>(A) who will perform the assessment; and<br>(B) time frames for completing assessment.<br>(5) client record management, including:<br>(A) persons authorized to document;<br>(B) transporting records;<br>(C) safeguard of records against loss, tampering, defacement or use by unauthorized persons;<br>(D) assurance of record accessibility to authorized users at all times; and<br>(E) assurance of confidentiality of records. | V 105 | | |

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| V 105 | Continued From page 1<br>(6) screenings, which shall include:<br>(A) an assessment of the individual's presenting problem or need;<br>(B) an assessment of whether or not the facility can provide services to address the individual's needs; and<br>(C) the disposition, including referrals and recommendations;<br>(7) quality assurance and quality improvement activities, including:<br>(A) composition and activities of a quality assurance and quality improvement committee;<br>(B) written quality assurance and quality improvement plan;<br>(C) methods for monitoring and evaluating the quality and appropriateness of client care, including delineation of client outcomes and utilization of services;<br>(D) professional or clinical supervision, including a requirement that staff who are not qualified professionals and provide direct client services shall be supervised by a qualified professional in that area of service;<br>(E) strategies for improving client care;<br>(F) review of staff qualifications and a determination made to grant treatment/habilitation privileges:<br>(G) review of all fatalities of active clients who were being served in area-operated or contracted residential programs at the time of death;<br>(H) adoption of standards that assure operational and programmatic performance meeting applicable standards of practice. For this purpose, "applicable standards of practice" means a level of competence established with reference to the prevailing and accepted methods, and the degree of knowledge, skill and care exercised by other practitioners in the field; | V 105 | | |

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| V 105 | Continued From page 2<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview the facility failed to ensure they followed their policy on "Sedative Hypnotic Policy (Benzodiazepine free)" for one of twenty four audited clients (#10). The findings are:<br><br>Review on 2/27/19 of "Sedative Hypnotic Policy (Benzodiazepine Free" revealed:<br>-"Current consumers with urine toxicology drug screens that are positive for sedative hypnotics or other evidence of continued sedative hypnotics, will be placed on dose hold, staffed by the OTP medical provider and his/her clinician and their take home privileges suspended until the consumer has a minimum of 3 consecutive negative urine toxicology drug screens over a 3 month period and is in compliance with their treatment plan. Medication tapers will be initiated as per the Guidelines for Methadone and Suboxone Dosing for Clients with Positive Urine Toxicology or Prescriptions for Sedative Hypnotics."<br><br>Review on 2/26/19 of client #10's record revealed:<br>-Date of Admission of 12/21/17<br>-Diagnosis of Moderate Opioid Use Disorder<br><br>Review on 2/26/19 of client #10's Urinalysis Drug Screen (UDS) revealed:<br>-"10/18/18- positive for Benzo<br>-10-22-18- positive for Benzo" | V 105 | V 105<br><br>We have contracted with a new lab effective April 15, 2019. We will have quicker access to results (24-48 hours) and the capability to print a list of substance specific drug screens at that time.<br><br>• The lead nurse will be responsible for printing a list of all clients with positive drug screens on Mondays for the Leadership Team Meeting and on Thursdays for the Treatment Team Meeting. Positive drug screens will be discussed in these meetings.<br>• Clients who are positive for benzodiazepines will be placed on a taper and lose take homes immediately.<br>• Counselors will discuss any positive drug screen results at each client contact. | |

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| V 105 | Continued From page 3<br><br>Further review on 2/26/19 of client #10's Medication Administration Record (MAR) revealed:<br>-Through out the dates of 10/18/18-1/23/19 client #10 continued to dose at 170 milligrams daily with no taper as a result of benzo positive UDS's.<br><br>Review on 2/26/19 of the Client #10's notes revealed:<br>-Counselor Note dated 10/15/19 revealed, "Struggling with Benzo craving because of Father's death."<br>-No other notes entered from counselor or doctor for next two months.<br><br>During interview on 2/26/19 client #10 stated:<br>-Had a history of using heroin/pills, benzo's and marijuana.<br>-Was dosing at 170 milligrams of methadone, but moved up to 190 milligrams about 45 days ago.<br>-Was having withdrawals around midnight, felt his dose was not holding.<br>-Last saw the doctor when he increased his dose last month.<br>-Had not been on any taper.<br>-Had not seen a counselor in a few months, "honestly I did not know who my counselor was for a while, because my old one left."<br>-I met with new counselor a week ago.<br><br>During interview on 2/26/19 the Program Lead revealed:<br>-When a client test positive for Benzo's, they should be immediately flagged and reviewed by the doctor within 24 hours of receiving lab results.<br>-The dose is reduced and they are placed on a taper until they have a benzo free UDS. | V 105 | • Peer reviews of charts will be conducted quarterly and monitored by the OTP Program Manager and the OTP Lead Counselor.<br>• Future plans are for HL7 integration with our EMR with the ability to flag clients with positive drug screens.<br><br>We are in the process of revising all of our policies and procedures, including the program policies such as the Sedative Hypnotic policy for the opioid treatment program. The revised policies will be shared with all staff and supervision to ensure consistent care. | |

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| V 105 | Continued From page 4<br>-Reviewing client #10, it did not appear that a counselor or doctor was made a ware of this UDS, there is no taper put in place or notes from counselor or doctor to reflect this was addressed.<br><br>During interview on 2/26/19 the Doctor stated:<br>-They had been having lots of issues with the lab they were using with getting results back in a timely manner.<br>-Started having issues with the lab's turn around time last summer, and they were working to increase those times, but the company had decided to go with a new lab.<br>-"Sometimes, by the time I get the positive results, they have already tested negative again."<br>-"I remember getting the results for [client #10's] positive benzo, by the time I saw it, his next test the Clonazepam levels had decreased which let me know he had not used more."<br>-Did not do a taper because it appeared to be trending down.<br>-They have a "flat policy" that says if benzo positive, they would start a taper to decrease two percent every other day until reached 40 milligrams or benzo free UDS.<br>-Did not complete note regarding this matter or not aware if the counselor at the time was aware of the positive benzo UDS. | V 105 | | |
| V 112 | 27G .0205 (C-D)<br>Assessment/Treatment/Habilitation Plan<br><br>10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN<br>(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 | V 112 | | |

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| V 112 | Continued From page 5<br>receive services beyond 30 days.<br>(d) The plan shall include:<br>(1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement;<br>(2) strategies;<br>(3) staff responsible;<br>(4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both;<br>(5) basis for evaluation or assessment of outcome achievement; and<br>(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.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interviews, facility staff failed to assure strategies were developed, implemented and the treatment plan reviewed at least annually to meet the needs of one of two audited deceased clients (deceased client #2). The findings are:<br><br>Review on 2/26/19 of the Incident Reporting Improvement System (IRIS) revealed an incident report dated 11/13/18. Review of the report revealed:<br>-Deceased Client #2 (DC#2)was reported dead by her boyfriend on 11/10/18<br>-DC#2's boyfriend reported she died of an overdose<br>-DC#2 last dosed on site on 11/10/18 | V 112 | V 112<br><br>We have hired a new medical provider for our opioid treatment program.<br><br>• We will be requiring all clients on the opioid treatment program to see one of the medical providers at least annually.<br><br>Documentation training is being conducted with all of our opioid treatment program clinicians to ensure that any referrals to a higher level of care are fully documented.<br><br>• Training in development of Person Centered Plans was conducted in November, and all clinicians are reviewing their caseloads to ensure that PCPs are rewritten yearly and updated timely. | |

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| V 112 | Continued From page 6<br><br>Review on 2/26/19 of client DC#2 record revealed:<br>-An admission date of 2/4/16 and a discharge date of 11/12/18<br>-A physician's history and health check dated 2/9/16 had medical mental health issues including Opioid Use Disorder, Depression and Attention Deficit Hyperactivity Disorder<br>-A treatment plan dated 5/12/16 with goals addressing: improvement of personal life by maintaining ongoing abstinence from all mood altering drugs as evidenced by random urine drug screen (UDS), establishment of sober peer group , participation in group and individual therapy and medication administration treatment<br>-Weekly UDS between September 5, 2019 and October 30, 2019 were all positive for mood altering substances not prescribed by a physician including: an Amphetamine, Crystal Meth and Fentanyl<br>-No evidence of additional therapeutic strategies or interventions nor updated treatment plan since 2016<br><br>During an interview on 2/27/19, Clinical Case Manager #2 (CCM#2) reported:<br>-DC#2 had been on weekly UDS's for "quite a while"<br>-He encouraged her to see the physician for a dose evaluation but he did not think she kept the appointment<br>-DC#2 did not want to go up on her dose because it made her sleepy<br>-He looked in the record and DC#2 had not seen the doctor since September 2017<br>-Her case was reviewed by the treatment team but not in the 6 months prior to her death<br>-He discussed additional Substance Abuse | V 112 | • Chart reviews are being conducted at each supervision meeting to identify problems with documentation.<br>• Peer reviews of charts will be conducted quarterly and monitored by the OTP Program Manager and the OTP Lead Counselor.<br><br>We have contracted with a new lab effective April 15, 2019. We will have quicker access to results (24-48 hours) and the capability to print a list of substance specific drug screens at that time.<br><br>• The lead nurse will be responsible for printing a list of all clients with positive drug screens on Mondays for the Leadership Team Meeting and on Thursdays for the Treatment Team Meeting. | |

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| V 112 | Continued From page 7<br>Intensive Outpatient Program (SAIOP) with the DC#2 but "she was dealing with one crisis after another" including the recent death of her mother and brother, caring for her son and work<br>-DC#2 was engaged in therapy and did not test positive for Benzodiazepines<br><br>During an interview on 2/27/19, the Program Lead reported if a client had repeated positive UDS for crystal meth, he would increase UDS's and Controlled Substance Reporting System (CSRS) checks and possibly refer back to SAIOP or additional therapy. | V 112 | • Clients who are positive for benzodiazepines will be placed on a taper and lose take homes immediately.<br>• Counselors will discuss any positive drug screen results at each client contact. | |
| V 233 | 27G .3601 Outpt. Opiod Tx. - Scope<br><br>10A NCAC 27G .3601 SCOPE<br>(a) An outpatient opioid treatment facility provides periodic services designed to offer the individual an opportunity to effect constructive changes in his lifestyle by using methadone or other medications approved for use in opioid treatment in conjunction with the provision of rehabilitation and medical services.<br>(b) Methadone and other medications approved for use in opioid treatment are also tools in the detoxification and rehabilitation process of an opioid dependent individual.<br>(c) For the purpose of detoxification, methadone and other medications approved for use in opioid treatment shall be administered in decreasing doses for a period not to exceed 180 days.<br>(d) For individuals with a history of being physiologically addicted to an opioid drug for at least one year before admission to the service, methadone and other medications approved for use in opioid treatment may also be used in maintenance treatment. In these cases, methadone and other medications approved for | V 233 | We are in the process of revising all of our policies and procedures, including the program policies. The revised policies will be shared with all staff and supervision to ensure consistent care. | |

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| V 233 | Continued From page 8<br>use in opioid treatment may be administered or dispensed in excess of 180 days and shall be administered in stable and clinically established dosage levels.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, the facility failed to coordinate services with other prescribing physicians for one of twenty four audited clients (#32). The finding is:<br><br>Review on 2/26/19 of client #32's record revealed:<br>-Admitted:10/11/18<br>-Diagnosis: Substance Use<br>-Physician's note dated 12/7/18 Subutex dose increased from 16 mg to 20 mg..was in the hospital for seizures...taking "Keppra twice a day (still)"<br>-No evidence of medications prescribed by another physician...no copy of prescribing physician's orders for Keppra or nurse documentation client brought in prescription.<br>-9 Urine Drug Screens collected between December 1, 2018-February 16, 2019 showed evidence of positive results for medications (Ativan, Zoloft, Gabapentin, Tramadol and Adderall) sporadically. No evidence these medications were prescribed.<br><br>During interview on 2/27/19, client #32's counselor reported:<br>-A few days, prior to this interview, client #32 had gone to the hospital for seizures.<br>-She was not aware client #32's did not have her prescribed medications listed in the record<br>-She would remind client #32 of the | V 233 | V 233<br>• Release of Information forms will be signed for medical providers at intake and annually.<br>• At each check of the Controlled Substance Reporting System, release of information forms will be signed for any prescriber of reported substances.<br>• A form letter requesting coordination of care will be sent to all medical providers identified.<br>• Peer reviews of charts will be conducted quarterly and monitored by the OTP Program Manager and the OTP Lead Counselor.<br>We are in the process of revising all of our policies and procedures, including the program policies. The revised policies will be shared with all staff and supervision to ensure consistent care. | |

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| V 233 | Continued From page 9<br>requirement but felt it was not a priority for client #32 as she did not receive take homes<br><br>During interview on 2/27/19, the Program Lead reported:<br>-A list of prescribed medications should be noted in the client's records. | V 233 | | |
| V 238 | 27G .3604 (E-K) Outpt. Opiod - Operations<br><br>10A NCAC 27G .3604 OUTPATIENT OPIOD TREATMENT. OPERATIONS.<br>(e) The State Authority shall base program approval on the following criteria:<br>(1) compliance with all state and federal law and regulations;<br>(2) compliance with all applicable standards of practice;<br>(3) program structure for successful service delivery; and<br>(4) impact on the delivery of opioid treatment services in the applicable population.<br>(f) Take-Home Eligibility. Any client in comprehensive maintenance treatment who requests unsupervised or take-home use of methadone or other medications approved for treatment of opioid addiction must meet the specified requirements for time in continuous treatment. The client must also meet all the requirements for continuous program compliance and must demonstrate such compliance during the specified time periods immediately preceding any level increase. In addition, during the first year of continuous treatment a patient must attend a minimum of two counseling sessions per month. After the first year and in all subsequent years of continuous treatment a patient must attend a minimum of one counseling session per month. | V 238 | | |

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| V 238 | Continued From page 10<br>(1) Levels of Eligibility are subject to the following conditions:<br>(A) Level 1. During the first 90 days of continuous treatment, the take-home supply is limited to a single dose each week and the client shall ingest all other doses under supervision at the clinic;<br>(B) Level 2. After a minimum of 90 days of continuous program compliance, a client may be granted for a maximum of three take-home doses and shall ingest all other doses under supervision at the clinic each week;<br>(C) Level 3. After 180 days of continuous treatment and a minimum of 90 days of continuous program compliance at level 2, a client may be granted for a maximum of four take-home doses and shall ingest all other doses under supervision at the clinic each week;<br>(D) Level 4. After 270 days of continuous treatment and a minimum of 90 days of continuous program compliance at level 3, a client may be granted for a maximum of five take-home doses and shall ingest all other doses under supervision at the clinic each week;<br>(E) Level 5. After 364 days of continuous treatment and a minimum of 180 days of continuous program compliance, a client may be granted for a maximum of six take-home doses and shall ingest at least one dose under supervision at the clinic each week;<br>(F) Level 6. After two years of continuous treatment and a minimum of one year of continuous program compliance at level 5, a client may be granted for a maximum of 13 take-home doses and shall ingest at least one dose under supervision at the clinic every 14 days; and<br>(G) Level 7. After four years of continuous treatment and a minimum of three years of | V 238 | | |

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| V 238 | Continued From page 11<br>continuous program compliance, a client may be granted for a maximum of 30 take-home doses and shall ingest at least one dose under supervision at the clinic every month.<br>(2) Criteria for Reducing, Losing and Reinstatement of Take-Home Eligibility:<br>(A) A client's take-home eligibility is reduced or suspended for evidence of recent drug abuse. A client who tests positive on two drug screens within a 90-day period shall have an immediate reduction of eligibility by one level of eligibility;<br>(B) A client who tests positive on three drug screens within the same 90-day period shall have all take-home eligibility suspended; and<br>(C) The reinstatement of take-home eligibility shall be determined by each Outpatient Opioid Treatment Program.<br>(3) Exceptions to Take-Home Eligibility:<br>(A) A client in the first two years of continuous treatment who is unable to conform to the applicable mandatory schedule because of exceptional circumstances such as illness, personal or family crisis, travel or other hardship may be permitted a temporarily reduced schedule by the State authority, provided she or he is also found to be responsible in handling opioid drugs. Except in instances involving a client with a verifiable physical disability, there is a maximum of 13 take-home doses allowable in any two-week period during the first two years of continuous treatment.<br>(B) A client who is unable to conform to the applicable mandatory schedule because of a verifiable physical disability may be permitted additional take-home eligibility by the State authority. Clients who are granted additional take-home eligibility due to a verifiable physical disability may be granted up to a maximum 30-day supply of take-home medication and shall | V 238 | | |

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| V 238 | Continued From page 12<br>make monthly clinic visits.<br>(4) Take-Home Dosages For Holidays: Take-home dosages of methadone or other medications approved for the treatment of opioid addiction shall be authorized by the facility physician on an individual client basis according to the following:<br>(A) An additional one-day supply of methadone or other medications approved for the treatment of opioid addiction may be dispensed to each eligible client (regardless of time in treatment) for each state holiday.<br>(B) No more than a three-day supply of methadone or other medications approved for the treatment of opioid addiction may be dispensed to any eligible client because of holidays. This restriction shall not apply to clients who are receiving take-home medications at Level 4 or above.<br>(g) Withdrawal From Medications For Use In Opioid Treatment. The risks and benefits of withdrawal from methadone or other medications approved for use in opioid treatment shall be discussed with each client at the initiation of treatment and annually thereafter.<br>(h) Random Testing. Random testing for alcohol and other drugs shall be conducted on each active opioid treatment client with a minimum of one random drug test each month of continuous treatment. Additionally, in two out of each three-month period of a client's continuous treatment episode, at least one random drug test will be observed by program staff. Drug testing is to include at least the following: opioids, methadone, cocaine, barbiturates, amphetamines, THC, benzodiazepines and alcohol. Alcohol testing results can be gathered by either urinalysis, breathalyzer or other alternate scientifically valid method. | V 238 | | |

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| V 238 | Continued From page 13<br>(i) Client Discharge Restrictions. No client shall be discharged from the facility while physically dependent upon methadone or other medications approved for use in opioid treatment unless the client is provided the opportunity to detoxify from the drug.<br>(j) Dual Enrollment Prevention. All licensed outpatient opioid addiction treatment facilities which dispense Methadone, Levo-Alpha-Acetyl-Methadol (LAAM) or any other pharmacological agent approved by the Food and Drug Administration for the treatment of opioid addiction subsequent to November 1, 1998, are required to participate in a computerized Central Registry or ensure that clients are not dually enrolled by means of direct contact or a list exchange with all opioid treatment programs within at least a 75-mile radius of the admitting program. Programs are also required to participate in a computerized Capacity Management and Waiting List Management System as established by the North Carolina State Authority for Opioid Treatment.<br>(k) Diversion Control Plan. Outpatient Addiction Opioid Treatment Programs in North Carolina are required to establish and maintain a diversion control plan as part of program operations and shall document the plan in their policies and procedures. A diversion control plan shall include the following elements:<br>(1) dual enrollment prevention measures that consist of client consents, and either program contacts, participation in the central registry or list exchanges;<br>(2) call-in's for bottle checks, bottle returns or solid dosage form call-in's;<br>(3) call-in's for drug testing;<br>(4) drug testing results that include a review of the levels of methadone or other | V 238 | | |

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| V 238 | Continued From page 14<br>medications approved for the treatment of opioid addiction;<br>(5) client attendance minimums; and<br>(6) procedures to ensure that clients properly ingest medication.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, the facility failed to assure all requirements were met for take home eligibility for one of twenty four audited clients (#31).<br><br>Review on 02/26/18 of client #31's record revealed:<br>-Admitted: 10/7/15<br>-Diagnoses: Sever Opioid Use, Diabetic<br>-Current Methadone Dosage 104 mg<br>-Take home level Phase 2 end 12/26/18...phase 4 start 12/27/18 and maintained<br><br>Review on 2/26/19 of client #31's Urinalysis Drug Screen (UDS) collected 1/8/19 & 1/15/19 revealed positive for Fentanyl<br><br>Review on 2/26/19 of client #31's counselor notes dated 1/14/19 revealed client admitted to using.<br><br>During interview on 2/27/18, client #31's counselor reported:<br>-It was an miscommunication with medical that an intervention regarding client #31's take home was not implemented. Intervention could include suspension, level dropped, contract developed or other methods identified by the treatment team.<br>-Sometimes, medical drops the level prior to | V 238 | V 238<br><br>We have contracted with a new lab effective April 15, 2019. We will have quicker access to results (24-48 hours) and the capability to print a list of substance specific drug screens at that time.<br><br>• The lead nurse will be responsible for printing a list of all clients with positive drug screens on Mondays for the Leadership Team Meeting and on Thursdays for the Treatment Team Meeting.<br>• Clients who are positive for fentanyl will lose take homes immediately.<br>• Counselors will discuss any positive drug screen results at each client contact. | |

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| V 238 | Continued From page 15<br>counselor having met with the client.<br><br>During interview on 2/27/19, the Program Lead reported:<br>-There should have been some type of review and intervention for client #31 due to the positive testing with take homes especially since his take homes had just been increased<br><br>This deficiency constitutes a re-cited deficiency and must be corrected within 30 days. | V 238 | • Peer reviews of charts will be conducted quarterly and monitored by the OTP Program Manager and the OTP Lead Counselor. | |
| V 536 | 27E .0107 Client Rights - Training on Alt to Rest. Int.<br><br>10A NCAC 27E .0107 TRAINING ON ALTERNATIVES TO RESTRICTIVE INTERVENTIONS<br>(a) Facilities shall implement policies and practices that emphasize the use of alternatives to restrictive interventions.<br>(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.<br>(c) Provider agencies shall establish training based on state competencies, monitor for internal compliance and demonstrate they acted on data gathered.<br>(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 | V 536 | We are in the process of revising all of our policies and procedures, including the program policies. The revised policies will be shared with all staff and supervision to ensure consistent care. | |

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| V 536 | Continued From page 16<br>course.<br>(e) Formal refresher training must be completed by each service provider periodically (minimum annually).<br>(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.<br>(g) Staff shall demonstrate competence in the following core areas:<br>(1) knowledge and understanding of the people being served;<br>(2) recognizing and interpreting human behavior;<br>(3) recognizing the effect of internal and external stressors that may affect people with disabilities;<br>(4) strategies for building positive relationships with persons with disabilities;<br>(5) recognizing cultural, environmental and organizational factors that may affect people with disabilities;<br>(6) recognizing the importance of and assisting in the person's involvement in making decisions about their life;<br>(7) skills in assessing individual risk for escalating behavior;<br>(8) communication strategies for defusing and de-escalating potentially dangerous behavior; and<br>(9) positive behavioral supports (providing means for people with disabilities to choose activities which directly oppose or replace behaviors which are unsafe).<br>(h) Service providers shall maintain documentation of initial and refresher training for at least three years.<br>(1) Documentation shall include:<br>(A) who participated in the training and the | V 536 | | |

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| V 536 | Continued From page 17<br>outcomes (pass/fail);<br>(B) when and where they attended; and<br>(C) instructor's name;<br>(2) The Division of MH/DD/SAS may review/request this documentation at any time.<br>(i) Instructor Qualifications and Training Requirements:<br>(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.<br>(2) Trainers shall demonstrate competence by scoring a passing grade on testing in an instructor training program.<br>(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.<br>(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.<br>(5) Acceptable instructor training programs shall include but are not limited to presentation of:<br>(A) understanding the adult learner;<br>(B) methods for teaching content of the course;<br>(C) methods for evaluating trainee performance; and<br>(D) documentation procedures.<br>(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.<br>(7) Trainers shall teach a training program aimed at preventing, reducing and eliminating the | V 536 | | |

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| V 536 | Continued From page 18<br>need for restrictive interventions at least once annually.<br>(8) Trainers shall complete a refresher instructor training at least every two years.<br>(j) Service providers shall maintain documentation of initial and refresher instructor training for at least three years.<br>(1) Documentation shall include:<br>(A) who participated in the training and the outcomes (pass/fail);<br>(B) when and where attended; and<br>(C) instructor's name.<br>(2) The Division of MH/DD/SAS may request and review this documentation any time.<br>(k) Qualifications of Coaches:<br>(1) Coaches shall meet all preparation requirements as a trainer.<br>(2) Coaches shall teach at least three times the course which is being coached.<br>(3) Coaches shall demonstrate competence by completion of coaching or train-the-trainer instruction.<br>(l) Documentation shall be the same preparation as for trainers.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview the facility failed to ensure three of six staff (#1, #2, #3) had training in Alternative to Restrictive Interventions prior to providing services. The findings are:<br><br>During interview on 2/27/19 the Program Director stated:<br>-The company used North Carolina | V 536 | V 536<br><br>Our Clinical Quality Director is scheduled to be an in-house trainer in Adaptive De-escalation Alternatives. Her training is scheduled for March 25th and 26th.<br><br>• She will complete training of all opioid treatment program staff by April 10th.<br>• New staff and interns will receive the training in orientation.<br>• All existing staff will receive the training by the end of the fiscal year.<br>• Our policies are being updated to include this new curriculum.<br>• Human Resources is in the process of reviewing all personnel training charts to ensure all required training has been completed. | |

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| V 536 | Continued From page 19<br>Interventions (NCI) for their curriculum for Alternatives to Restrictive Interventions.<br><br>Review on 2/27/19 of staff #1's record revealed:<br>-Hire date of 3/5/18.<br>-NCI completed on 10/8/18.<br><br>Review on 2/27/19 of staff #2's record revealed:<br>-Hire date of 5/29/18.<br>-NCI completed 7/19/18.<br><br>Review on 2/27/19 of staff #3's record revealed:<br>-Hire date of 7/30/18<br>-Helping Others Prevent Escalation (HOPE) completed 9/6/18<br>-NCI not completed<br><br>During interview on 2/27/19 the Quality Manager stated:<br>-Not aware NCI had to be completed prior to employees providing services.<br>-Usually get them scheduled after they are hired.<br>-Not aware they could not use different curriculums in Alternative to Restrictive Interventions training.<br>-Thought if an employee was hired and they had a current training, it would be sufficient.<br><br>This deficiency constitutes a re-cited deficiency and must be corrected within 30 days. | V 536 | • Human Resources will use Relias to track the in-house training in Adaptive De-escalation Alternatives with a completion and expiration date. Relias will provide reminders to staff, supervisors, and human resources when trainings are due. | |