

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL084-085	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/10/2019
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NAME OF PROVIDER OR SUPPLIER LORETTA'S PLACE	STREET ADDRESS, CITY, STATE, ZIP CODE 109 PENNY STREET ALBEMARLE, NC 28001
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(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
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V 000	<p>INITIAL COMMENTS</p> <p>A complaint survey was completed on 6/10/19. The complaints were substantiated (Intakes #NC151464, #NC151505). Deficiencies were cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .1900 Psychiatric Residential Treatment Facility.</p>	V 000		
V 517	<p>27E .0104(c-d) Client Rights - Sec. Rest. & ITO</p> <p>10A NCAC 27E .0104 SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT AND PROTECTIVE DEVICES USED FOR BEHAVIORAL CONTROL</p> <p>(c) Restrictive interventions shall not be employed as a means of coercion, punishment or retaliation by staff or for the convenience of staff or due to inadequacy of staffing. Restrictive interventions shall not be used in a manner that causes harm or abuse.</p> <p>(d) In accordance with Rule .0101 of Subchapter 27D, the governing body shall have policy that delineates the permissible use of restrictive interventions within a facility.</p> <p>This Rule is not met as evidenced by: Based on records review and interviews, the facility failed to ensure restrictive interventions were not employed as a means of retaliation by staff and not used in a manner that caused harm or abuse affecting 3 of 3 audited clients (#1, #2 and #3) and 1 of 1 audited former client (FC#4). The findings are:</p> <p>Cross Reference: 10A NCAC 27E .0108 TRAINING IN SECLUSION, PHYSICAL</p>	V 517	<p style="text-align: center;">DHSR - Mental Health</p> <p style="text-align: center;">JUN 28 2019</p> <p style="text-align: center;">Lic. & Cert. Section</p> <p>On June 7, 2019, the EBPI Trainer, Program Director and Direct Care Supervisor trained staff on the rule 10A.NCAC.27.0104(a) (b) (c) (d) concerning seclusion, physical restraint, isolation and retaliation. Premier also discussed the importance of not using restrictive interventions for any retaliatory means. Program Director/Supervisor explained that staff must use the "tap out" method when feeling frustrated and angry to avoid retaliation.</p> <p>Staff must adhere to the "tap out" method and if staff fails to adhere to the method, it was related in the mandatory staff meeting that disciplinary action would be automatic termination.</p> <p>In addition, Premier invited the EBPI developer, Mr. Richard McDonald to the mandatory meeting to demonstrate all proper restraints.</p>	06/07/2019 (Completed)

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Clarena Lacy

TITLE

Program Director

(X6) DATE

6/25/2019

Division of Health Service Regulation

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STREET ADDRESS, CITY, STATE, ZIP CODE

LORETTA'S PLACE

**109 PENNY STREET
ALBEMARLE, NC 28001**

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V 517	<p>Continued From page 1</p> <p>RESTRAINT AND ISOLATION TIME-OUT V537 Based on records review and interviews, the facility failed to ensure staff demonstrated competency in the proper use of restrictive interventions and alternatives to these procedures for 2 of 5 staff (#2, #3).</p> <p>Review on 5/30/19 of staff #1's personnel record revealed: -rehire date of 8/17/18 with the job title of Residential Counselor; -prior hire date of 11/23/15 with resignation date of 12/13/17; -completed trainings on 12/15/18, 5/17/19 and 5/20/19 in the current physical restraint curriculum used by the facility of EBPI (Evidence Based Protective Interventions); -completed trainings in prior curriculum used by the facility of North Carolina Interventions (NCI) on 11/24/15, 8/12/16, 9/9/16; -completed training in prior curriculum used by the facility of Non-Violent Crisis Intervention/Crisis Prevention Institute (CPI) on 10/20/16, 2/10/17 and 10/18/17; -completed training in the following: De-escalating Hostile Clients 10/12/16, Calming Children in Crisis 10/12/16, Abuse and Neglect 12/30/16, Post Traumatic Stress Disorder (PTSD) 8/20/18, Attention Deficit Hyperactivity Disorder (ADHD) 8/17/18, Disruptive Disorders 8/17/18.</p> <p>Review on 5/30/19 of staff #4's personnel record revealed: -hire date of 3/7/19 with the job title of Residential Counselor; -EBPI training completed on 3/7/19 and 5/17/19.</p> <p>Finding #1: Review on 5/29/19 of client #1's record revealed: -admission date of 3/19/19 with diagnoses of</p>	V 517		

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V 517	<p>Continued From page 2</p> <p>PTSD (Post Traumatic Stress Disorder), ADHD (Attention Deficit Hyperactivity Disorder), Disruptive Mood Dysregulation Disorder(DMDD) and Enuresis; -age 10 years old; -Comprehensive Clinical Assessment(CCA) dated 2/28/19 documented behaviors including aggression, poor impulse control, struggles with routines and expectations, angers quickly, poor attention span, easily frustrated, triggered by peers, flashbacks and nightmares related to his trauma history, bites and hits others.</p> <p>Review on 5/29/19 of an incident report dated 5/15/19 regarding client #1 and completed by staff #1 revealed the following documented: -client #1 was poking himself with pens to leave marks; -staff prompted him to stop; -client #1 asked for some scissors; -staff explained the rules of the facility and he could not have any scissors; -client #1 got mad, threw balled up paper at staff; -client used profanity towards staff, and told staff not to talk to him; -client #1's legal guardian called and staff proceeded to go to the phone to talk to his legal guardian about his current behaviors; -client #1 yelled "no you can't tell her s**t!" and punched staff in the face; -staff blocked client #1's second punch and tried to place client #1 in a restraint; -client #1 spit in staff's face when staff was trying to block the punches; -client #1 then went to the floor and punched staff in the genital area; -client #1 began kicking and wrapped himself around staff's legs; -"Staff used EBPI training to properly restrain [client #1] to stop him from being so combative."</p>	V 517		
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V 517	<p>Continued From page 3</p> <p>Interview on 5/29/19 with client #1 revealed: -been restrained, staff #1 hurt him; -staff #1 threw him against the wall; -staff #1 grabbed him by both ankles and dragged him across the floor; -other clients saw it happen, staff #4 saw it happen; -sometimes, when getting restrained, staff puts his hands behind his back but he does not remember which staff.</p> <p>Interview on 5/29/19 with client #2 revealed: -was entering the unit upstairs with staff #4; -saw staff #1 had client #1 by his foot; -saw staff #1 dragging client #1 on the floor by his foot.</p> <p>Interview on 5/29/19 with client #3 revealed: -staff #1 "went wild on the night shift;" -don't remember what client #1 was doing; -saw client #1 on the floor on his back, staff #1 was holding him down on the floor by his shoulders; -staff #4 told staff #1 to back off and he did; -client #1 crawled on the floor "real fast," spitting and got staff #1's leg and tried to bite it; -staff #1 took client #1's legs by his ankles and dragged him across the floor; -staff #4 saw it happen.</p> <p>Interview on 6/3/19 with staff #4 revealed: -did not see all of client #1's restraint; -was walking in the door of the unit, had been on the basketball court with client #2 and another client; -as entered the unit, saw client #1 hit staff #1; -staff #1 restrained client #1 on the floor; -observed staff #1 pick up client #1 by his ankles at one point;</p>	V 517		
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- can't say she saw staff #1 drag client#1.

Interview on 6/4/19 with staff #1 revealed:

- was rehired in 8/2018;
- been trained in NCI, CPI and EBPI;
- did a refresher in EBPI recently;
- facility now uses EBPI;
- client #1 was making spit balls and throwing them at staff #1, cussing, put one spit ball in staff #1's hair, staff #1 prompted client #1 to stop cussing and stop horseplaying;
- client #1 wanted some scissors, told client #1 no scissors because of his behaviors;
- client #1's legal guardian called and staff #1 went to relay to her client #1's recent behaviors;
- client #1 cussed staff #1 and punched him in the face;
- staff #1 blocked the other punches, client #1 got on the ground, grabbed staff #1's leg and tried to bite it;
- staff #1 tried to place client #1 in a restraint, finally was able to do a sitting restraint and placed client #1 in a hug like;
- let client #1 go after three minutes;
- denied ever grabbed client #1 by his feet/ankles;
- denied ever dragged client #1.

Finding #2:

Review on 5/29/19 of client #2's record revealed:

- admission date of 4/17/19 with diagnosis of DMDD;
- age 14 years old;
- CCA dated 4/15/19 documented client #2 had self-harm behaviors, poor coping skills, verbal and physical aggression, assaultive towards others, history of abuse and neglect, impulsive, anxiety, abandonment issues.

Review on 5/29/19 of an incident report dated 5/15/19 regarding client #2 and completed by

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V 517	<p>Continued From page 5</p> <p>staff #1 revealed the following documented: -client #2 became upset because he felt his peer was being treated unfairly; -while staff was trying to get the peer calmed down, client #2 was being "very belligerent" and "stated he wanted to be restrained because he was bigger and tougher;" -client #2 kept advancing towards staff trying to get around second staff; -client #2 was yelling constant threats, hitting staff, spitting on staff several times; -second staff tried to process with client and asked him to use his coping skills; -again client #2 tried to get around the second staff who was trying to process with him to get to targeted staff; -client #2 spit in staff's face; -client #2 tried to backhand swing at staff, attempting to hit staff in the face; -staff blocked the swing and initiated EBPI physical intervention; -client #2 was very combative and "staffs hand scratched consumer neck trying to secure the restraint;" -client #2 dropped to the floor and staff released him.</p> <p>Review on 5/29/19 of the Nursing Post Restraint Evaluation form dated 5/15/19 regarding client #2 revealed: -"red marks to rt. (right) side of neck;" -"red bruises to right side of neck (no bleeding) (no scratches)."</p> <p>Review on 5/29/19 of a form titled "Investigation Report" dated 5/16/19 completed by the Program Director revealed the following documented: -allegations client #2 was injured during a restraint; -scratches on the collarbone;</p>	V 517		
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V 517	<p>Continued From page 6</p> <p>-interviewed staff and residents; -determined staff #1 "did not deliberately cause any harm to [client #2];" -when staff #1 attempted to do an EBPI restraint, "he accidentally made contact with [client #2] on the upper right shoulder area;" -"During the course of the investigation, [staff #1] was suspended and will be retrained on EBPI."</p> <p>Review on 5/29/19 of a hand written statement by staff #4 dated 5/15/19 revealed the following documented: "I walked in from the hallway taking two clients outside, a behavior was occurring. [Staff #1] was attempting to restrain [client #1] when [client #1] was on the floor being combative. During this time, [client #2] was agitated and began screaming at [staff #1] to stop. [Client #2] was going to go towards [staff #1] when I took him to his room to calm him down. He then went past me and spit on [staff #1]. [Staff #1] came towards [client #2] and I tried to tap him out. [Staff #1] bumped me out of the way and became in contact with [client #2]. [Staff #1] left marks on [client #2] doing an improper restraint. In my opinion, he was not intentionally hurting [client #2] but should have tapped out due to his frustration."</p> <p>Interview on 5/29/19 with client #2 revealed: -was upset because saw staff #1 dragging client #1 across the floor; -was with staff #4; -got upset and threw his shoes at staff #1; -staff #1 came after him, chased him around the table upstairs on the unit, then went back to dealing with client #1; -client #2 went back to his room, all other clients in their rooms; -felt "[staff #1] still hurting [client #1];" -"[client #1] was screaming, yelling, crying;"</p>	V 517		
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V 517	<p>Continued From page 7</p> <p>-"[client #1] is nine years old, felt I had to take up for him, try to get [staff #1] to come after me instead;"</p> <p>-he came out of his room and spit on staff #1;</p> <p>-staff #1 "talked junk, don't remember what he said;"</p> <p>-client #2 spit on staff #1 again;</p> <p>-staff #1 pushed staff #4 out of the way;</p> <p>-staff #4 was trying to protect him;</p> <p>-staff #1 grabbed client #2 by the back of his neck, squeezing it, pushing him towards the floor;</p> <p>-client #2 was bent over at his waist, staff #1 kept squeezing his neck and pushing down until he(staff #1) was finished talking, pushed client #2 to the floor;</p> <p>-staff #4 was "hovering" over client #2;</p> <p>-went to see the nurse afterwards, she put stuff on his neck, it was over.</p> <p>Interview on 5/29/19 with client #1 revealed:</p> <p>-staff #1 grabbed client #2 by the back of his neck;</p> <p>-staff #1 forced client #2 to bend over;</p> <p>-staff #1 left bruises on client #2's neck and shoulders;</p> <p>-staff #4 pulled staff #1 back.</p> <p>Further interview on 6/3/19 with staff #4 revealed:</p> <p>-had client #2 outside and was walking into unit;</p> <p>-client #2 got upset about client #1;</p> <p>-client #2 said "not hurt that little kid;"</p> <p>-got client #2 to come with her to his room;</p> <p>-client #2 kept looking over her shoulder at what was going on between client #1 and staff #1;</p> <p>-client #2 walked past her, she prompted him, stepped in front of him to block him from staff #1;</p> <p>-she "knew [staff #1] was escalated by his demeanor, needed a break;"</p> <p>-client #2 ran out of his room and threw a book at staff #1;</p>	V 517		

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- staff #4 got between client #2 and staff #1, saying "I got this, I got this" to staff #1;
- tried to tap staff #1 out;
- client #2 spit on staff #1 again;
- staff #1 put his hands on her shoulders and moved her out of the way;
- staff #1 "got mad" and saying "you're not going to spit on me;"
- could tell staff #1 was frustrated;
- other two staff on floor were in with other clients in their rooms, not involved;
- thought staff #1 was going to do a restraint when he went towards client #2;
- told staff #1 do not restrain, "back off;"
- staff #1 put his hands on the back of client #2's neck and was pressing client down,
- staff #1 was pushing client #2 down by his neck so client #2 was bent forward;
- client #2 ended up on the floor, can not say if staff #1 forced him to floor or if client #2 let himself down to the floor;
- lasted about a minute;
- there were marks on client #2's neck/shoulder;
- client #2 was crying, staff #1 got up and walked off;
- took client #2 to go see the nurse.

Interview on 6/3/19 with the Nurse revealed:

- went downstairs after client #1's restraint;
- did not observe what happened to client #2;
- client #2 told her staff #1 grabbed him by his neck;
- marks on left side of his neck;
- staff #4 took a picture of the marks and gave information to the Program Director.

Further interview on 6/4/19 with staff #1 revealed:

- client #2 said staff #1 restrained client #1 for no reason;
- client #2 threw stuff at him;

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V 517	<p>Continued From page 9</p> <ul style="list-style-type: none"> -he was trying to clean up stuff client #1 had thrown about on the unit floor earlier; -staff #4 was trying to keep client #2 from coming towards him; -client #2 came towards him, staff #4 stood in front of client #2; -client #2 threatened staff #1 and said "you going to restrain me next?" -client #2 spit on him 3-4 times, then pulled a fast one on staff #4, got around her; -spit in staff #1's face, "disrespectful;" -client #2 "started going nuts;" -tried to put client #2 in a restraint, client #2 tried to punch him; -grabbed client #2 by his wrist, client #2 went to the floor, client #2 yelled, was acting "overdramatic;" -once client #2 was on the floor, let client #2 go; -client #2 said staff #1 improperly restrained him, client #2 said staff #1 was "too rough with him;" -denied had client #2 by his neck, had his shoulder, not his neck; -had to go through EBPI training again and process with administration how to do things differently next time. <p>Review on 6/5/19 of a picture of client #2's injuries produced by the Program Director revealed:</p> <ul style="list-style-type: none"> -red marks and scratches on his neck; -3 red linear bruises on client #2's neck near his collarbone. <p>Interview on 6/5/19 with the Program Director and the Human Resources(HR) Director/EBPI Instructor revealed:</p> <ul style="list-style-type: none"> -was not aware staff #1 dragged client #1 by his ankles; -was not aware staff #1 grabbed client #2 by the back of his neck; 	V 517		
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V 517	<p>Continued From page 10</p> <ul style="list-style-type: none"> -will not tolerate this type of behavior from staff; -did not get the same information during the investigation; -was not aware of the improper restrictive interventions occurring; -talk about EBPI once a month at every staff meeting; -also talk about what can be done differently as review restrictive interventions that have happened; -have new staff and seasoned staff, all get trained and get refreshers; -will retrain all staff and focus on what physical restraints look like and as well as tapping out when frustrated and need a break. <p>Review on 6/5/19 of a Plan of Protection dated 6/5/19 and completed by the HR Director/EBPI Instructor revealed the following documented:</p> <ul style="list-style-type: none"> -"Effective 6/5/19, Premier Services of Carolina, Inc. will train all staff on the proper manner to conduct EBPI training. Staff will demonstrate and must pass with a 98% or better. The training will consist of a group of six for 1 hour period. If the staff member is less than 98%, - he/she will not be able to be on the floor and must retrain." -"To ensure this type of improper restraint does not occur, Premier's EBPI trainer will be notified immediately and the staff member will receive severe disciplinary action but not limited to termination. The EBPI trainer will report to the Program Director and present sign in sheet and he/she will ensure the certificate is signed together. To ensure staff taps out due to anger; retaliation-Automatic Termination and the staff refuses to be tapped out physically or verbally, this leads to Automatic Termination. Friday: Program Director and HR/EBPI Trainer will call a mandatory meeting on 6/7/19." 	V 517		
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V 517	Continued From page 11 Client #2 was grabbed by the back of his neck and forced to the floor by staff #1 during a behavior which resulted in red bruising on the lower side of his neck. Client #1 was dragged by his ankles across the floor by staff #1 during a behavior. Client #3 was restrained improperly by staff #2 and staff #3 with his left arm bent behind his back causing pain. FC#4 was restrained improperly by staff #2 and staff #3 with his left arm bent behind his back causing a sprained elbow and a sprained shoulder. Training in restraints completed by staff #1, staff #2 and staff #3 did not teach any of the above listed physical interventions. This constitutes a Type A1 rule violation for serious harm and abuse and must be corrected within 23 days. An administrative penalty of \$1,500.00 is imposed. If the violation is not corrected within 23 days, an additional administrative penalty of \$500.00 per day will be imposed for each day the facility is out of compliance beyond the 23rd day.	V 517		
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	V 537		

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V 537	<p>Continued From page 12</p> <p>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.</p> <p>(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.</p> <p>(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.</p> <p>(e) Formal refresher training must be completed by each service provider periodically (minimum annually).</p> <p>(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.</p> <p>(g) Acceptable training programs shall include, but are not limited to, presentation of:</p> <ol style="list-style-type: none"> (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 	V 537		
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V 537	<p>Continued From page 13</p> <p>psychological well-being of the client and the safe use of restraint throughout the duration of the restrictive intervention;</p> <p>(6) prohibited procedures;</p> <p>(7) debriefing strategies, including their importance and purpose; and</p> <p>(8) documentation methods/procedures.</p> <p>(h) Service providers shall maintain documentation of initial and refresher training for at least three years.</p> <p>(1) Documentation shall include:</p> <p>(A) who participated in the training and the outcomes (pass/fail);</p> <p>(B) when and where they attended; and</p> <p>(C) instructor's name.</p> <p>(2) The Division of MH/DD/SAS may review/request this documentation at any time.</p> <p>(i) Instructor Qualification and Training Requirements:</p> <p>(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.</p> <p>(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.</p> <p>(3) Trainers shall demonstrate competence by scoring a passing grade on testing in an instructor training program.</p> <p>(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.</p> <p>(5) The content of the instructor training the service provider plans to employ shall be approved by the Division of MH/DD/SAS pursuant</p>	V 537		

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V 537	<p>Continued From page 14</p> <p>to Subparagraph (j)(6) of this Rule.</p> <p>(6) Acceptable instructor training programs shall include, but not be limited to, presentation of:</p> <p>(A) understanding the adult learner;</p> <p>(B) methods for teaching content of the course;</p> <p>(C) evaluation of trainee performance; and</p> <p>(D) documentation procedures.</p> <p>(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.</p> <p>(8) Trainers shall be currently trained in CPR.</p> <p>(9) Trainers shall have coached experience in teaching the use of restrictive interventions at least two times with a positive review by the coach.</p> <p>(10) Trainers shall teach a program on the use of restrictive interventions at least once annually.</p> <p>(11) Trainers shall complete a refresher instructor training at least every two years.</p> <p>(k) Service providers shall maintain documentation of initial and refresher instructor training for at least three years.</p> <p>(1) Documentation shall include:</p> <p>(A) who participated in the training and the outcome (pass/fail);</p> <p>(B) when and where they attended; and</p> <p>(C) instructor's name.</p> <p>(2) The Division of MH/DD/SAS may review/request this documentation at any time.</p> <p>(l) Qualifications of Coaches:</p> <p>(1) Coaches shall meet all preparation requirements as a trainer.</p> <p>(2) Coaches shall teach at least three</p>	V 537		
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V 537	<p>Continued From page 15</p> <p>times, the course which is being coached.</p> <p>(3) Coaches shall demonstrate competence by completion of coaching or train-the-trainer instruction.</p> <p>(m) Documentation shall be the same preparation as for trainers.</p> <p>This Rule is not met as evidenced by: Based on records review and interviews, the facility failed to ensure staff demonstrated competency in the proper use of restrictive interventions for 2 of 5 staff (#2, #3). The findings are:</p> <p>Review on 5/30/19 of staff #2's personnel record revealed: -hire date of 2/20/16 with the job title of Residential Counselor; -promotion to Lead Residential Counselor on 1/22/19; -completed trainings on 12/15/18 and 5/17/19 in the current physical restraint curriculum used by the facility of EBPI (Evidence Based Protective Interventions); -completed trainings in the following prior restraint curriculums used by the facility: NCI (North Carolina Interventions) 9/9/16, 2/23/16, CPI (Non Violent Crisis Intervention/Crisis Prevention Institute) 8/11/17, 10/4/17, 9/27/18, 11/16/18.</p> <p>Review on 5/30/19 of staff #3's personnel record revealed: -hire date of 2/21/18 with the job title of Residential Counselor; -completed trainings in EBPI 11/29/18 and 5/17/19.</p>	V 537	<p>On June 11, 2019- June 13, 2019, the EBPI instructor held a mandatory retraining on Physical interventions.</p> <p>During the training hour(s), the trainer discussed de-escalation and how to approach a situation when a client is in crisis. She also discussed that physical restraints must be the last resort. For the remainder of the class, all Staff had to demonstrate different physical restraint techniques. On June 14, 2019, Staff had to demonstrate 100% competency. Any score below, would result being suspended off of the floor and retrained until the 100% was met.</p> <p>To continue with training, the EBPI trainer will meet with staff quarterly to ensure on-going competency.</p> <p>In addition to the quarterly, Premier has developed and has implemented a Random Physical Restraint Monitoring Tool. (Attachment A) This tool will be used randomly to maintain competency. This form can also be used during an active restraint/intervention as well as maintaining competency.</p> <p>If the tool reveals a restraint /intervention is incorrect, if it is an active restraint, the employee will be immediately removed. At this time, the employee is mandated must monitor the proper technique until the he/she can demonstrate the proper technique.</p> <p>If the tool is used for a random restraint/intervention check, and the technique is incorrect, he/she will be</p>	06/14/2019 (completed)- On-going

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			immediately retrained and must prove 100% competency.	
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V 537	<p>Continued From page 16</p> <p>Review on 5/30/19 of the EBPI training video of the physical restraints and information revealed:</p> <ul style="list-style-type: none"> -one person standing restraint: staff behind client, has a grasp with his hands on client wrists, crosses arms at lower forearms in front of client below waist, staff leg between client's legs and staff leans back; -sitting one person restraint: client sitting in front of staff on floor, staff behind client, has client's arms crossed in front of client, staff holding client's wrists; -transport 2 person technique: client standing, staff on each side of client, have their arms nearest client hooked under client's armpits, client's arms are straight down, each staff holding at the wrist; -2 person restraint: client standing, staff on each side, holding arms by wrists across client midsection, each staff's legs between client legs; -"Although the amount of physical control needed depends on how severe the person's behavior is, your physical abilities and speed are also important considerations;" -"The hold should be adjusted so that you are using as much strength as needed." <p>Finding #1: Review on 5/29/19 of client #3's record revealed:</p> <ul style="list-style-type: none"> -admission date of 5/2/19; -15 years old; -diagnoses of Intermittent Explosive Disorder, Attention Deficit Hyperactivity Disorder, Oppositional Defiant Disorder and Anxiety Disorder; -Comprehensive Clinical Assessment(CCA) dated 4/4/19 documented behaviors of aggression, defiance, tantrums, threats to others, suicidal ideation and involvement with the legal system. 	V 537		
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V 537	<p>Continued From page 17</p> <p>Review on 5/29/19 of an incident report dated 5/5/19 regarding client #3 revealed the following documented:</p> <ul style="list-style-type: none"> -standing restraint for duration of 5 minutes; -client #3 was defiant, disruptive, banging on pole in unit, using profanity; -staff prompted and tried to redirect to an activity/coping skill, client #3 refused; -client #3 stormed off into the hallway beside the unit; -banged on the brick walls and the door leading to the inventory room; -staff offered to take client #3 on a therapeutic walk, encouraged client #3 to count to 10, told client #3 he could go to his room and take a time out, could talk about what is bothering him; -client #3 refused all options to de-escalate; -client #3 began banging on the protective wall socket, kicking and hitting the walls; -client #3 threatened to attack staff, staff prompted client #3 to remain a safe distance; -client #3 rushed towards staff with his fist balled up ; -staff initiated EBPI restraint. <p>Review on 5/29/19 of the Nursing Post Restraint Evaluation form dated 5/5/19 regarding client #3 revealed client #3 complained his left arm was hurting and no injuries were found.</p> <p>Interview on 5/29/19 with client #3 revealed:</p> <ul style="list-style-type: none"> -been here 3-4 weeks; -had only one restraint since being here; -was standing up for his friend (Former Client/FC#4); -don't remember how he ended up in the hallway; -remember the restraint, "arm bout got broke;" -was standing up during the restraint, facing the wall; -staff #2 had his left arm, holding it between his 	V 537		
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V 537	<p>Continued From page 18</p> <p>wrist and his elbow and put his arm behind his back twisting his arm upward, hurting his left arm; -staff #3 was on the other side of him, had his arm under client #3's armpit and was lifting him up on his tiptoes; -staff #2 then took his arm and bent it back, client #3 ended up on floor on his rear; -stayed on floor, stomach on his knees with arm behind him held by staff #3; -later client #3 asked staff #2 why staff #2 did that to him and staff #2 reported "that was how he was trained."</p> <p>Interview on 6/4/19 with staff #3 revealed: -trained on EBPI; -watched the training video, had to practice and demonstrate the restraints; -remember did a standing restraint on client #3; -client #3 took a swing at staff #2, "went ballistic," went after staff; -remember he was on one side of client #3, staff #2 was on the other side; -did not remember client #3 complaining of his arm hurting, don't remember anything else.</p> <p>Interview on 5/29/19 with staff #2 revealed: -trained in EBPI; -did two man standing restraint, one staff on each side client #3; -placed a hand on the wrist and a hand on the upper arm; -had refresher training in EBPI recently.</p> <p>Finding #2: Review on 5/23/19 of Former Client (FC#4)'s record revealed: -admission date of 4/10/19 with diagnoses of Post traumatic Stress Disorder and Intermittent Explosive Disorder; -16 years old;</p>	V 537		

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V 537	<p>Continued From page 19</p> <p>-CCA dated 3/26/19 documented behaviors including "explosive episodes," history of suicidal ideation, verbal and physical aggression, assaulted younger peer, assaulted birth father.</p> <p>Review on 5/23/19 of in incident report dated 5/5/19 regarding FC#4 revealed the following documented:</p> <ul style="list-style-type: none"> -standing restraint for the duration of 3 minutes; -during lunch meal, FC#4 wanted to go back to unit upstairs and not wait on his peers; -staff prompted him to remain in cafeteria until peers finished then all would go up to the unit; -FC#4 got upset, started using profanity; -staff prompted FC#4 to stop using profanity and asked him if he wanted to sit alone away from peers until peers finish their lunch; -FC#4 continued cursing and got up attempting to leave area without permission; -staff prompted FC#4 to come back to area and sit down, FC#4 walked over and punched the wall; -FC#4 became extremely combative and staff utilized EBPI physical restraint; -during EBPI restraint, FC#4 jerked away and fell to the floor; -FC#4 calmed down after 5 minutes. <p>Review on 5/23/19 of the Nursing Post Restraint Evaluation form dated 5/5/19 regarding FC#4 revealed no injuries were noted and no complaints of pain were noted.</p> <p>Review on 5/23/19 of a discharge summary from a local hospital emergency room regarding FC#4 dated 5/6/19 documented the following:</p> <ul style="list-style-type: none"> -reason for visit: shoulder pain, swelling; -discharge diagnosis: sprain of left shoulder, sprain of left elbow. 	V 537		

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V 537	<p>Continued From page 20</p> <p>Interview on 5/28/19 with FC#4 revealed: -got upset, heard client #3 screaming, dumped a lot of water on the floor to get staff attention on him and away from client #3; -staff #2 grabbed his left arm, put it behind his back, yanked it upward, just the one arm; -was in between two walls, in a corner; -complained about his arm hurting; -went to the local emergency room, got X-rays done on his arm; -don't remember other staff who helped with restraint; -restrained another time, same way, arm behind back.</p> <p>Further interview on 5/29/19 with client #3 revealed: -did not see FC#4's restraint; -could hear FC#4 because was in next room; -did overhear FC#4 saying "Why are you bending my arm, you M****r F****r."</p> <p>Further interview on 6/4/19 with staff #3 revealed: -assisted with FC#4's restraint; -remember FC#4 was trying to self harm; -EBPI restraint involved one staff on each side of client, bring client's arm to your side, hold at wrist, your legs in front of their legs; -no part of EBPI has client arms behind their backs; -FC#4's restraint happened really quickly; -happened in the cafeteria; -staff #2 grabbed FC#4 to stop him from sliding into the wall; -floor was wet because FC#4 had poured water on the floor; -FC#4 was about to fall, staff #3 tried to keep him from falling; -that is all he can remember about the restraint.</p>	V 537		

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V 537	<p>Continued From page 21</p> <p>Further interview with staff #2 on 5/29/19 revealed:</p> <ul style="list-style-type: none"> -in the cafeteria, FC#4 was sitting with a peer, got upset, cursing and saying he wished everyone would die; -talked about wanting to kill himself; -was punching walls, tore the band off his shirt sleeve and tried to pull it tight around his neck; -had poured water on the floor, floor was slippery; -did an EBPI restraint, each staff on each side, got one arm each and put by their sides, hand on wrists; -when FC#4 fell to the floor, released him; -staff #3 released FC#4 before he did, he held on to FC#4's arm because he did not want FC#4 to hit the floor hard when he dropped to floor; -if both released at the same time, FC#4 would have hit the floor hard; -"maybe I did not let go early enough;" -"don't know how elbow hyperextended." <p>Interview on 6/3/19 with staff #4 revealed:</p> <ul style="list-style-type: none"> -been on her job since March 2019; -watched the video, demonstrated, talked about a lot of de-escalation; -proper EBPI restraint staff put clients arms behind their back; -"like a cop puts you in handcuffs;" -staff pout their hands on the client's shoulders; -take client's arms by their wrists and put at their back; -client's hands behind their rear. <p>Interview on 6/3/19 with staff #5 revealed:</p> <ul style="list-style-type: none"> -been trained in NCI, CPI and now EBPI; -went over techniques in training, practiced on co-workers in training, had training books; -one person restraint cross arms in front of client; -2 man restraint one staff on each arm, stand straight up; 	V 537		
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(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 22</p> <ul style="list-style-type: none"> -arms never go behind clients' back, not like cops. <p>Interview on 5/30/19 with the Human Resources Director /EBPI Instructor revealed:</p> <ul style="list-style-type: none"> -EBPI focuses more on de-escalation than physical restraints; -Five Units focus on the de-escalation piece of EBPI; -discuss triggers, how to communicate with clients, how to push back authority, let clients have choices, body language and how portray yourself, know your own triggers and attitudes, learn when restraints are needed and when not needed; -EBPI consists of blocks, releases, walks with client, sitting restraint and standing restraint; -teach staff not all techniques fit all clients; -arms always held at the side; -transport is not a hold; -if the client falls to the floor, release them; -arms are never behind client's backs; -never twist client's arms behind them, "never, never;" -review incident reports and go over in meeting what could have been done better to avoid restraints. <p>This deficiency is cross referenced into 10A NCAC 27E .0104 SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT AND PROTECTIVE DEVICES USED FOR BEHAVIORAL CONTROL V517 for a Type A1 rule violation and must be corrected within 23 days.</p>	V 537		

ATTACHMENT A

This form is for TRAINING PURPOSES ONLY.

PLEASE PROVIDE THE FOLLOWING EMPLOYEE INFORMATION

Employee Name: _____ Employee Title: _____
Employee Name: _____ Employee Title: _____
Time: _____ : _____ a.m./ p.m.

PLEASE INDICATED TYPE OF INTERVENTION USED

- Arm Grabs
- Two hand blocks
- Upper Cut Punch
- Simple Hold and Release
- Transportation Techniques
- Therapeutic Walk to Chair
- Hair Pull
- Bite Release
- Therapeutic Hold Wrap- One Person
- Escape Attempt
- Back Choke
- Therapeutic Hold Wrap- Two People

Empty rectangular box for notes or additional information.

ACTION TAKEN

Random Check/Intervention Active Restraint/Intervention

COMMENTS:

Four horizontal lines for writing comments.

Please obtain all signatures prior to submitting this form to Human Resources

Program Director/EBPI Trainer/Supervisor/ Lead Direct Care
Employee Signature / _____ Date

Printed Name
Employee Signature / _____ Date

Date